

LONG-TERM CARE AND MEDICAID: SPIRALING COSTS AND THE NEED FOR REFORM

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED NINTH CONGRESS FIRST SESSION

APRIL 27, 2005

Serial No. 109-24

Printed for the use of the Committee on Energy and Commerce



Available via the World Wide Web: <http://www.access.gpo.gov/congress/house>

U.S. GOVERNMENT PRINTING OFFICE
20-749PDF

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

JOE BARTON, Texas, *Chairman*

RALPH M. HALL, Texas	JOHN D. DINGELL, Michigan
MICHAEL BILIRAKIS, Florida <i>Vice Chairman</i>	<i>Ranking Member</i>
FRED UPTON, Michigan	HENRY A. WAXMAN, California
CLIFF STEARNS, Florida	EDWARD J. MARKEY, Massachusetts
PAUL E. GILLMOR, Ohio	RICK BOUCHER, Virginia
NATHAN DEAL, Georgia	EDOLPHUS TOWNS, New York
ED WHITFIELD, Kentucky	FRANK PALLONE, Jr., New Jersey
CHARLIE NORWOOD, Georgia	SHERROD BROWN, Ohio
BARBARA CUBIN, Wyoming	BART GORDON, Tennessee
JOHN SHIMKUS, Illinois	BOBBY L. RUSH, Illinois
HEATHER WILSON, New Mexico	ANNA G. ESHOO, California
JOHN B. SHADEGG, Arizona	BART STUPAK, Michigan
CHARLES W. "CHIP" PICKERING, Mississippi, <i>Vice Chairman</i>	ELIOT L. ENGEL, New York
VITO FOSSELLA, New York	ALBERT R. WYNN, Maryland
ROY BLUNT, Missouri	GENE GREEN, Texas
STEVE BUYER, Indiana	TED STRICKLAND, Ohio
GEORGE RADANOVICH, California	DIANA DEGETTE, Colorado
CHARLES F. BASS, New Hampshire	LOIS CAPPS, California
JOSEPH R. PITTS, Pennsylvania	MIKE DOYLE, Pennsylvania
MARY BONO, California	TOM ALLEN, Maine
GREG WALDEN, Oregon	JIM DAVIS, Florida
LEE TERRY, Nebraska	JAN SCHAKOWSKY, Illinois
MIKE FERGUSON, New Jersey	HILDA L. SOLIS, California
MIKE ROGERS, Michigan	CHARLES A. GONZALEZ, Texas
C.L. "BUTCH" OTTER, Idaho	JAY INSLEE, Washington
SUE MYRICK, North Carolina	TAMMY BALDWIN, Wisconsin
JOHN SULLIVAN, Oklahoma	MIKE ROSS, Arkansas
TIM MURPHY, Pennsylvania	
MICHAEL C. BURGESS, Texas	
MARSHA BLACKBURN, Tennessee	

BUD ALBRIGHT, *Staff Director*

DAVID CAVICKE, *Deputy Staff Director and General Counsel*
REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

NATHAN DEAL, Georgia, *Chairman*

RALPH M. HALL, Texas	SHERROD BROWN, Ohio
MICHAEL BILIRAKIS, Florida	<i>Ranking Member</i>
FRED UPTON, Michigan	HENRY A. WAXMAN, California
PAUL E. GILLMOR, Ohio	EDOLPHUS TOWNS, New York
CHARLIE NORWOOD, Georgia	FRANK PALLONE, Jr., New Jersey
BARBARA CUBIN, Wyoming	BART GORDON, Tennessee
JOHN SHIMKUS, Illinois	BOBBY L. RUSH, Illinois
JOHN B. SHADEGG, Arizona	ANNA G. ESHOO, California
CHARLES W. "CHIP" PICKERING, Mississippi	GENE GREEN, Texas
STEVE BUYER, Indiana	TED STRICKLAND, Ohio
JOSEPH R. PITTS, Pennsylvania	DIANA DEGETTE, Colorado
MARY BONO, California	LOIS CAPPS, California
MIKE FERGUSON, New Jersey	TOM ALLEN, Maine
MIKE ROGERS, Michigan	JIM DAVIS, Florida
SUE MYRICK, North Carolina	TAMMY BALDWIN, Wisconsin
MICHAEL C. BURGESS, Texas	JOHN D. DINGELL, Michigan, (Ex Officio)
JOE BARTON, Texas, (Ex Officio)	

C O N T E N T S

	Page
Testimony of:	
Allen, Kathryn G., Director, Health Care, Medicaid and Private Health Insurance Issues, U.S. Government Accountability Office	78
Feder, Judith, Dean, Public Policy Institute, Georgetown University	140
Hansen, Jennie Chin, Board of Directors, Class of 2008, AARP	132
Holtz-Eakin, Douglas, Director, Congressional Budget Office	31
Ignagni, Karen, President and CEO, America's Health Insurance Plans ...	104
Krooks, Bernard A., Littman Krooks LLP	115
McClellan, Mark B., Administrator, Centers for Medicare and Medicaid Services	20
Moses, Stephen, President, Center for Long-term Care Financing	111
O'Shaughnessy, Carol V., Specialist in Social Legislation, Domestic Social Policy Division, Congressional Research Service	90
Page, Lee, Associate Advocacy Director, Paralyzed Veterans of America ...	73
Stucki, Barbara, Project Manager, the National Council of the Aging	125
Material submitted for the record by:	
Allen, Kathryn G., Director, Health Care, Medicaid and Private Health Insurance Issues, U.S. Government Accountability Office, response for the record	169
Feder, Judith, Dean, Public Policy Institute, Georgetown University, response for the record	173
Holtz-Eakin, Douglas, Director, Congressional Budget Office, response for the record	172
O'Shaughnessy, Carol V., Specialist in Social Legislation, Domestic Social Policy Division, Congressional Research Service, response for the record	168
Page, Lee, Associate Advocacy Director, Paralyzed Veterans of America, response for the record	174

LONG-TERM CARE AND MEDICAID: SPIRALING COSTS AND THE NEED FOR REFORM

WEDNESDAY, APRIL 27, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to other business, at 11:24 a.m., in room 2123 of the Rayburn House Office Building, Hon. Nathan Deal (chairman) presiding.

Members present: Representatives Deal, Bilirakis, Upton, Gillmor, Norwood, Cubin, Shimkus, Shadegg, Buyer, Pitts, Bono, Ferguson, Rogers, Myrick, Burgess, Barton (ex officio), Brown, Waxman, Rush, Eshoo, Green, Strickland, Capps, Allen, Baldwin, and Dingell (ex officio).

Also present: Representatives Wilson and Engel.

Staff present: Chuck Clapton, chief health counsel; David Rosenfeld, majority counsel; Jeanne Haggerty, Majority professional staff; Eugenia Edwards, legislative clerk; Brandon Clark, health policy coordinator; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; Jessica McNiece, research assistant; and David Vogel, research assistant.

Mr. DEAL. The subcommittee will come to order. We will have members joining us, I am sure, in just a few minutes, so we are pleased to open this hearing today, and we have two panels.

The first is two individuals, very distinguished individuals, Dr. Mark McClellan, who is the Administrator of the Centers for Medicare and Medicaid Services, and Dr. Douglas Holtz-Eakin, who is the Director of the Congressional Budget Office.

Gentlemen, we are pleased to have you with us today. This is a hearing that I think all of us have looked forward to. Dr. McClellan, I realize that your testimony was a little late getting in, and we would just encourage you to get it here a little earlier. It will facilitate, perhaps, some of the members and their questions, and understanding your testimony today. But we are pleased to have both of you here.

I will recognize myself, as I have just done, for purposes of an opening statement. As we deal with the question, in particular, of the spiraling costs of Medicaid, we are hearing from our Governors, as I am sure Dr. McClellan, you are hearing from Governors as well. My Governor and many Governors that members of our subcommittee have met with, both formally and informally, are con-

tinuing to tell us that they simply can't afford the program, as it is currently in place, and they are requesting that we make changes.

Hopefully, some time during this session of Congress, we will have the opportunity to address that issue in greater detail. But I think your testimony here today will lay a groundwork for us to understand what the parameters of the problem are, and perhaps some of the solutions that may be available to us.

Everybody, I am sure, has their own personal story about dealing with the problems of long-term healthcare, for example, which is a major component, obviously, of the Medicaid expenditures. I have been jokingly told by some that I need a license to operate my home, because some 8 years ago, by fortuitous circumstances, my mother, who is now 98, came to live with us, because she had to have a leg amputated, and was bound in a wheelchair, and could no longer live alone. About the same point in time, my wife's mother and father came to live with us as well. Her mother had been diagnosed with Alzheimer's, and she has since passed away, but her father, who is now 91, continues to live with me, and with us in our home.

But these are not unusual circumstances for families to face. Very few have the opportunity to take their parents into their home and provide for them. And it is not that my parents or my mother or my father-in-law are wealthy people. They are retired public schoolteachers, but they have not gone into a publicly financed Medicaid nursing home environment. There are many others out there who would like to have avoided a nursing home as well, and I think one of the options that hopefully we will explore, as we visit this issue of long-term healthcare in particular, is how do we afford families the opportunity to provide for themselves and for their loved ones, in an environment outside of a nursing home. Many people would desire, I think, that option, and I think that under our current rules, we don't have the flexibility to allow States to design programs that perhaps would accommodate those wishes.

There are many other facets, obviously, of the Medicaid problem, but the one that I continue to harp on, and it is an essential ingredient that I think causes the problem, and if we can fix it, will perhaps provide the solution, and that is, the current absence of individual responsibility in the program as it is designed. It is the lack of individual responsibility that causes the concerns of hospitals, who constantly tell me—in a meeting I had recently with my local hospital, that in excess of 70 percent of their emergency room visits could probably be classified as non-emergency, and virtually all of those are being paid for through Medicaid, a program that is costing us huge amounts of money at both the State and Federal levels.

It is that lack of personal responsibility in the design of the program that needs to be fixed. If we do that, and Governors have continually indicated that they would like to be able to address that issue, that if we do that, I think hopefully we can design something, as we approach the problems and look for solutions, something that will individually make us responsible for recognizing that this is not just something that somebody else is going to pay

for for us. We have a part in it, and we ought to be responsible in our participation.

At this time, I would recognize Mr. Brown, the Ranking Member of the subcommittee, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman. I echo the chairman's words and comments about the testimony of Dr. McClellan. He came to us at 10:15 last evening, and I know the staff on both sides of the aisle works really hard, but not all of them were there when it came, and then it was edited this morning, in sort of a second round. I hope you will work to do better than that. I know it is always difficult to prepare for these hearings.

I commend the chairman for enabling the subcommittee to consider the future of long-term care, one of our healthcare system's most critical issues. I would like to suggest, though, a subtle but important shift in perspective. Instead of focusing on spiraling long-term care costs, let us focus on spiraling long-term care needs. Our population is aging, and the need for long-term care is keeping pace. We should focus on the actual issue, not one of its manifestations.

If we frame this discussion around the need to reduce long-term care costs, we are basically saying that the cost of caring for individuals is more important than the individuals themselves. If, on the other hand, we focus on the need for long-term care, we will not, then, neglect important considerations. For example, we know there are gaps in access to long-term, particularly home and community-based services. Is that fact more or less important than long-term care—than the fact that long-term care costs are growing? And we know that regardless of how these services are financed in the future, there are elderly and severely disabled Americans who need long-term care now. Medicaid covers 70 percent of that care. If we cut Medicaid funding today, we place particularly vulnerable segments of our population at risk.

We can discuss reverse mortgage and long-term care insurance and personal responsibility until we are blue in the face, and there is a role for all of that, but the fact is, if we cut Medicaid today, we jeopardize the health and safety of people whom we know, of real people. All of our efforts to prepare for the future don't change that basic fact. If you think I am overly dramatic, talk to an elderly person at an understaffed nursing home. Talk to her family, especially. Do we really think that today's nursing homes are filled with scheming seniors who are free riding on the taxpayer's dime? There will always be people who try to game the system, occasionally some successfully, but most Medicaid beneficiaries don't want to be Medicaid beneficiaries. They simply have no choice.

If we focus on long-term care needs, rather than long-term care costs, we will make sure our efforts to prevent asset transfers don't disenfranchise people in real need. We will make sure the long-term care insurers do not cherry pick or fail to deliver adequate benefits. We will think carefully before forcing people in an ownership society to give up their homes in order to get needed care. Instead of focusing on how to reform Medicaid to address spiraling costs, let us focus on how to make sure every American who needs long-term care has access to it.

That means promoting private, long-term care savings. It means investing in Medicaid as a cost effective safety net for people in need. Absent a universal, long-term care system, there will of course always be people in need. I understand Dr. McClellan will talk about the President's commitment to home and community-based care, and I share both Dr. McClellan's and the President's enthusiasm for it. However, home and community-based care waivers typically have enrollment caps. Making these waivers permanent, as the President proposes, doesn't expand access to home and community-based care. Additional funding is needed to accomplish that, and I don't recall any increase in funding for home and community-based care in the President's budget. This care is cost effective, but there is unmet need outside the nursing home population. Expanding access requires additional dollars.

That doesn't mean we should give up on the idea of expanding access to home and community-based services. In fact, promoting access to these services should be a priority. But championing the expansion of home and community-based care, and at the same time, pushing for cuts in Medicaid, is a little bit like handing a person an umbrella, then pushing him off a cliff. We can't reduce the long-term care—we can't reduce the need for long-term care by reducing our current investment in it.

It is important to plan for long-term care needs in the future. It is even more important to meet our long-term care commitments today. If we are willing to cut Medicaid without regard to those we hurt, why even bother with this hearing? Apparently, the best way to reduce Federal long-term care spending is simply to abandon those who rely on it. I think we should take a different path.

Thank you, Mr. Chairman.

Mr. DEAL. The Chair recognizes Dr. Norwood for an opening statement, 5 minutes.

Mr. NORWOOD. Thank you.

Mr. DEAL. Or 3 minutes, excuse me.

Mr. NORWOOD. Thank you very much, Mr. Chairman. Dr. McClellan, I am certainly happy to see you here, and thus have the opportunity to talk to you. I also would like to add to the fact that you need to tell your staff to get us your statement earlier. That is really unacceptable. It means to me you don't think we are important in this issue, and I know this committee finds this very important, or either—it is not important to you guys.

Few of us can be certain, frankly, how technological and medical developments will affect the issue of long-term care. What we do know, that the current system is not going to be able to meet the obligations of future generations. I think that is fairly clear. It is unfortunate that Americans have routinely avoided even thinking about long-term care until it is too late, yet some studies show that upwards of 40 percent of all Americans will need some sort of long-term care during their lives, and two-thirds of all recipients of long-term care must depend on Medicaid due to costs.

Recently, as I have recovered from my own little battle with idiopathic pulmonary fibrosis, I have experienced the difficulties of battling an illness, and I know the irreplaceable value of being able to turn to your family, to your wife, your faithful nurse. But many

are not so fortunate as I, and must rely on the government to provide for their care.

While Medicaid is primarily a source of financing for long-term care, the current financing system is ineffective, and is often taken advantage of. When our social programs were established, long-term care, as we know it, did not exist. People in need of support often received care from a family member, or were institutionalized. All of us can remember our grandfathers, grandmothers, and how long-term care was handled for them. As we enter the 21st century, care is significantly different. Unfortunately, our financing mechanisms have not kept pace. In that light, it is impossible to talk about reforming Medicaid without addressing the funding of long-term care, which I understand is about 56 percent of the cost.

Because Medicaid is an alternative to private insurance, the program encourages people, encourages people to drop coverage or avoid long-term care planning, and rely instead on this free Medicaid. Put simply, Medicaid discourages proper planning, and is quickly becoming a welfare program for middle income families. With clever estate planning and asset protection schemes, individuals can qualify for Medicaid and receive long-term care taxpayers' expense.

Moving away from such abuse would allow Medicaid to return to its proper mission, and I am sure everybody on this committee agrees with that. And it would provide a safety net for those who truly need it. I am looking forward to your testimony and your guidance on this very subject.

Mr. Chairman, thank you for the time.

Mr. DEAL. I thank the gentleman. The Chair now recognizes the gentlelady from California, Ms. Eshoo, for 3 minutes for an opening statement.

Ms. ESHOO. Thank you, Mr. Chairman, for holding this hearing, and also for the markup that we had earlier today. Welcome to our witnesses, Dr. McClellan, it is especially good to see you.

The financing of long-term care for the elderly population in our country really does need to be addressed, so that the challenge won't become our No. 1 economic problem of tomorrow. And I think that it is an economic issue. I don't know how many members of this committee have even taken advantage of buying long-term care insurance through the Federal Government. That might be an interesting little survey to do. I am one of them, because I can't help but think daily that if something happens to me, I—my young children are not going to be able to take care of me. So—but it is something that is expensive. It isn't something that everyone thinks that they need, because most of us think that we really are not in a position where we will need it.

It is an issue that touches all families at some point in our family life. I know that. I took care of my own father and mother, and we have heard stories from other members as well. While it is important to note that modern medical care has enabled more and more seniors to live longer, healthier lives, there still comes a time when families are simply not able to provide the full care for a loved one. The next step is professional care, either at home, in an assisted living facility, or in a nursing home. And none of us want to go to nursing homes. I think that is one thing that everyone

would raise their hands and say we are in agreement on. We just don't want to have to do that.

So given the level of care required, personal resources, and insurance benefits are often quickly used up. Approximately one in eight Americans is over the age of 65, and this number is expected to increase dramatically. Congress really should act before this wave of seniors overwhelms our current Nation's public programs for long-term care. We should look at long-term care creatively, and include a mix, I think, of approaches to address its viability by combining some of the aspects of incentives for private financing as well as public financing. Congress should also build on current programs by expanding eligibility.

Individuals have diverse needs and diverse circumstances, so I don't think that really one size fits all, and there should be a varied approach which would respond to these needs and these circumstances. I hope our witnesses today will address the long-term care partnership program, and whether or not this program would have much impact on the growth of Medicaid long-term care spending.

So I look forward to hearing the witnesses. They are all stars in their own right, and I think this committee can really gain from your vision and your experience and what you can tell us. Thank you, Mr. Chairman, and I yield back.

Mr. DEAL. I thank the gentlelady. I recognize the gentlelady, Ms. Cubin.

Ms. CUBIN. Thank you, Mr. Chairman. I agree with everything that has been said so far, and so I won't repeat that. But I do want to just add a couple other comments.

There are a lot of policies, rules and regulations, that simply waste money in Medicaid and Medicare when going into a nursing home. One example that I can think of is that you have to be in the hospital for 3 days before you can go into a nursing home, when the doctor knows very well, the family knows very well, that a nursing home is definitely what is needed.

My mother is in advanced stages of Alzheimer's right now, and my father has planned well financially for their retirement, but even at that, he says he will put her in a nursing home over his dead body. He is fortunate enough to be able to hire people to come in and help him right now, but that may not last forever, and I am concerned about what happens to people who have actually planned, but the prices are so exorbitant that the surviving spouse finds themselves in a situation where they can't afford to pay for their care, because the system is abused, and because there is waste in the system, and it is ineffective. We need an entirely new system, so with that, I will yield back my time.

Mr. DEAL. I thank the gentlelady. I recognize Mr. Allen for an opening statement.

Mr. ALLEN. Thank you, Mr. Chairman. I appreciate your convening this hearing to examine Federal long-term care initiatives. The need for long-term care is expected to grow substantially in the future, straining both public and private resources, so we need to bolster our long-term care infrastructure to meet the needs of our growing elderly population.

While most care is provided by family members, most public funding is for institutional care. Home and community-based services which can help heavily burdened families are available sometimes in a limited number of communities. In 2002, the Maine State legislature established a blue ribbon commission to examine the financing of long-term care, and consider opportunities to build on the Federal State commitment to caring for the State's elderly and disabled population.

Like most States, Maine found that nursing facility care is the most intensive and costly component of the long-term care system. Approximately 26,000 individuals in Maine received financial assistance for long-term care needs in 2001. Funds were allocated as follows: 61 percent for nursing facility, 20 percent for home-based care, and 19 percent for assisted living.

MaineCare, the State's Medicaid program, accounted for 70 percent of the patient days in nursing facilities. While the average cost, average actual cost of operations for nursing facilities was \$167 per day, the average allowable MaineCare costs was \$129 a day, and the average MaineCare reimbursement was \$117 per day. This rate includes both Federal and State dollars. In the national study being released today, the average shortfall in Medicaid nursing home reimbursement was \$12.58 per Medicaid patient day in 2002, translating into an annual shortfall of \$4.5 billion.

The point I am making here is that Medicaid is, in some instances, both wasteful and in some instances, simply not even coming close to paying for the costs of care of Medicaid patients. And I urge anyone looking at this area not to make assumptions about Medicaid across the spectrum of the country. My father was in a nursing home in Maine for about almost 2 years before he died, and I have been in a lot of nursing homes in Maine, and they are really stretched, and the people who are in them—Maine went through a process of really putting a lot of pressure on nursing home facilities, and encouraging community-based care over the last 15, 20 years, and the result is the people in nursing homes today in Maine really need to be there. I have no idea whether that is comparable in other States, but I do think that we have to deal with that particular issue, we have to deal with the fact that too many seniors don't want to think about, and middle aged people, don't want to think about being in long-term care, and that long-term care insurance sometimes is available, but often is too expensive for many people.

I look forward to hearing everything you have to say, and Mr. Chairman, I yield back.

Mr. DEAL. I thank the gentleman. The Chair recognizes Mr. Pitts for an opening statement. Ms. Bono. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I will submit my statement for the record as well. I just want to welcome Dr. McClellan. Good to see you again, sir, and just for the record, I too have long-term insurance. I have a private policy with GE Capital that I bought before coming to Congress.

Mr. DEAL. The Chair recognizes Ranking Member Dingell, for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you. I commend you for this hearing. As a Nation, we must develop a comprehensive, long-term

care policy in order to care for the 10 million people needing long-term care, and millions more that will need it in the next 20, 40, and 60 years. This is an important but complicated issue that the committee should be going into, so I thank you again for holding this hearing, as well as the witnesses who are here today to cooperate with us and educate us.

The majority of long-term care is provided for free through family or friends. Of the services purchased, Medicaid is the biggest payer, and the greatest safety net. It provides care for millions of elderly people and individuals with disabilities that have had the misfortune of becoming ill and needing help with their daily basic activities of ordinary life.

Sustained care is expensive and, without Medicaid, almost impossible for many. Most people struggle even with Medicaid to meet their most essential needs, such as eating, bathing, or going to the bathroom. Still, Medicaid always benefits from evaluation and updating. For example, we need to be rid of the program's bias toward institutional living, and provide home and community-based care where appropriate.

Unfortunately, instead of talking about ways to shore up Medicaid as a safety net, there are now efforts in this House of Representatives and in the administration, under the leadership of my Republican colleagues, in trying to actually cut it. The millions of ill people and individuals with disabilities who need long-term care services are a principal factor in increasing the cost of long-term care, not Medicaid. Medicaid is, on the contrary, one of the most efficient healthcare programs in the country.

The Governors Association is united in their opposition to Medicaid cuts. They recognize that the cuts will seriously harm States' abilities to provide the care that we as a compassionate society need to offer. We should be helping both the people who depend on the program, as well as ensuring that the States which manage the program are not harmed by decisions made here.

Aside from public financing, there is also an insurance industry out there selling long-term care insurance. While they may be providing a vital and important service, we need to avoid the mess we found ourselves in with the Medigap policies of the late 1980's. I do not want to be sorting through stories of unscrupulous insurers confusing and scaring beneficiaries into buying expensive policies that do little. I support long-term care insurance as an option, but there must be adequate protections with standardized policies and consumer protections, such as inflation protection, non-forfeiture provisions, and a minimum daily option for some. But some is the key word, whether through partnership programs with Medicaid or by itself, long-term insurance is not appropriate for millions of low and modest income families that are already finding it difficult to secure food, shelter, transportation, and healthcare, along with saving for retirement or education of their children.

Also, notably, creating incentives for the purchase of long-term care insurance may do little to alleviate the waste on public programs today. We need to develop a coherent long-term care policy that preserves and expands the safety nets of today, not cuts them.

I want to thank you, Mr. Chairman, and all of my colleagues, and the witnesses for their participation in this important hearing,

and I hope that we will, from it, be able to begin to make some judgments about where our priorities should be.

Thank you, Mr. Chairman.

Mr. DEAL. The Chair recognizes Mr. Ferguson for an opening statement.

Mr. FERGUSON. Thank you, Mr. Chairman, and thank you for calling this hearing, which will shed some light on an issue that requires urgent attention as a new generation of Americans, the baby boomers, grow closer to retirement age, and the Medicaid program continues to hemorrhage money.

Medicaid, as it stands right now, is financially unsustainable, and without true reform, the Medicaid program may not be around for those in future years for those who really need it. Today, we are looking at the issue of long-term care, an inevitability that many of us will rely upon in our later years, and a segment of our healthcare system which is draining billions of dollars from our Federal programs.

Long-term care services are a huge segment of our Nation's healthcare spending, totaling \$157 billion in 2002, representing 12 percent of all personal healthcare expenditures, but that total spending amount is expected to increase, as more people reach retirement age than there are, proportionally, younger workers to pay for and take care of their needs. The result is that public and private spending for long-term benefits for the elderly could double from 2000 to 2025, even assuming no expansion in benefits.

And increasingly, Medicaid has been relied upon to serve as a safety net for people requiring long-term care. In fiscal year 2003, Medicaid paid about \$83.8 billion for long-term care services, almost doubling from 10 years ago. These dollars primarily paid for institutional care and care in home and community-based settings.

Congress has made strides in addressing the issue of long-term care, but there is still a long way to go. For example, in 2000, Congress authorized a new grant program under the Older Americans Act, to provide information and assistance to caregivers, counseling, respite and other home and community-based services, to families caring for their frail older members.

We need to look further into alternatives to the current system, including building upon past reforms, encouraging long-term care insurance, and closing loopholes that people use to take advantage of Medicaid and other Federal programs. Thank you again, Mr. Chairman, for holding this important hearing, and I look forward to working with you, and I appreciate our witnesses for being here today, as we look to reform long-term care in our country.

I yield back.

Mr. DEAL. I thank the gentleman. The Chair recognizes Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman, and I want to thank my colleague, Ms. Baldwin, for allowing me to go before her, because I have to go to another hearing, but I appreciate that we have a chance to hold this hearing with the pair of docs that sits before us, a pair of doctors, Dr. McClellan and Dr. Holtz-Eakin, but we do have a paradox, and that is what are we going to do with the long-term care for elderly and disabled people?

Medicaid has served as a safety net for those very vulnerable people, and it is important that we continue the Medicaid program to serve that purpose until such time as we have an alternative. One alternative that obviously would have made sense would have been a social insurance system. Everybody would have paid into it, and then everybody who needs it would have it available. Most people are not going to need nursing home care. Others are looking at private long-term care policies, and I think that is a direction that we are probably going to be taking more and more.

The Federal Government now offers that to Federal employees, but as Mr. Dingell pointed out, we have got to make sure that these policies meet some kind of standards, because people can buy a policy, and find that they don't have much of anything if there is no inflation protection and otherwise. But Medicaid serves this important purpose now, to fund the safety net for those who desperately need it.

Now, I think all of us would like to see alternatives, in terms of letting people stay in the community and not go into a nursing home. Long-term care is not just nursing home care, and perhaps we can come up with some agreement along those lines. But I want to say one thing that should be very clear. For those who think that having a Medicaid program is the reason we have people without insurance is just absolutely absurd. It is only recently that insurance products have even been available, and we don't yet even have the standards to apply to those policies across the board.

I am also in strong disagreement with people who want to say that we should punitively go after seniors and force them to take out reverse mortgages, so that they should go out and then use that money to buy health insurance, long-term care policies. I don't know at what point you are going to do that in people's lives, but if you are going to do it at the point where they need nursing home care because they have less than \$2,000 in assets, that is—that doesn't make any sense at all.

Many States can go after the house afterwards, and some, in fact, do that. There should be a role for both private and public approaches to helping people with long-term care needs. I think we can look to see how to make the program better. But I think this is a program that is going to need more money, not less, and I hope we are not going to have people who voted for the instructions for conferees on the budget to say that there should not be a cut in Medicaid, turn around now and slash \$10 or \$20 billion of the Federal dollars for the Medicaid program, because making a policy in that context will certainly lead to disaster.

Thank you, Mr. Chairman.

Mr. DEAL. The Chair recognizes Mr. Bilirakis for an opening statement.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and I, along with you and the others, do want to welcome Dr. McClellan and Dr. Holtz-Eakin here today, and we apologize for your sitting there as long as you are just listening to us, gibberish up here, but in any case, thanks for being here, to you and all the other witnesses.

Mr. Chairman, we know that the escalating costs of long-term care is a very personal issue that has profound public policy implications. The CBO Office estimates that total spending on long-term

care exceeded \$200 billion last year, nearly a quarter of which was financed through the Medicaid program.

These costs are expected to rise substantially in the future as the need for long-term care grows with an ever increasing elderly population. The consequences of surging long-term care costs are significant for States and the Federal Government. Medicaid is becoming an increasing portion of Federal and State budgets, crowding out other important priorities. In my State of Florida, the Medicare spending accounts for \$14 billion, almost one quarter of the State's \$57 billion budget. Florida spent more than \$3 billion on long-term care through Medicaid last year, which will consume more than half of the State's budget in just 10 years at its current growth rate, and I think we all would agree that this growth is simply unsustainable.

The Florida Governor, Jeb Bush, has proposed an innovative approach to Medicaid reform, and already has developed programs through federally approved waivers to improve the management and coordination of long-term care and encourage home and community-based service programs. Other Governors, as we know, are experimenting with alternatives to meet the needs of their Medicaid populations.

Congress must act to help Florida and other States better control their Medicaid programs, and provide them the flexibility they need to meet the demands of the increasing number of Americans who receive long-term care services through Medicaid.

Mr. Chairman, Medicaid is a partnership. It is a partnership with the States. And whatever we do, we should not do and ignore, completely ignore what the States' wishes might be in that regard. We have got to sit down with them around a table and work it out together. We have to examine how to provide incentives to encourage people, especially younger generations, to plan for their future care. There is so much that we have to do, and I have a statement here, Mr. Chairman, I would like to put into the record, but I would basically say that first of all, for over the last 2 years, we had a taskforce from this subcommittee, which has been working on this subject. It was not done with the idea of tying it into budgets or budget decreases, or anything of that nature. It was done because we all felt that we have got to bring Medicaid up to par with what is happening today, and what the States' demands are.

And if this committee wants to reform Medicaid in such a way that it is not going to hurt the people who need it, that it will preserve the dignity of those who need long-term care services, et cetera, we can do it, if we put aside partisanship, and if we are willing to sit around a table and work together on a plan that will really work and not hurt those that really need it.

Thank you, Mr. Chairman.

Mr. DEAL. I thank the gentleman. The Chair recognizes Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman, and I thank all of the witnesses, both first and second panel, who will be testifying this afternoon. I look forward to engaging in an informative discussion about the options before us as a Congress and as a country.

Many of my colleagues, in their opening statements, have shared their personal accounts, probably because all of us learn a lot more

about long-term care through those very personal experiences we have than we do in any hearing room or briefing. I still recall a moment where I was sitting in a chair besides my grandmother's hospital bed, my grandmother who raised me since I was 2 months old, and hearing from the doctor, well, we need to discharge her, but she is not ready to go home yet, and you learn a lot about our long-term care system through those personal experiences. And through my grandmother, as her primary caregiver during her last years, I learned a lot about what many millions of American families struggle with, caring for someone with increasingly demanding needs, the painful decisions that families need to make when a loved one needs more care, or ultimately, to move into a nursing home, and about the financial stresses that are faced writing those very big monthly checks for nursing home care.

So I am pleased that this committee is taking up this very important issue. I think we have a real opportunity here to make some critical adjustments to Medicaid that will strengthen the program for future generations. As we consider the various options before us as a Congress and a country, I hope we keep numerous considerations in mind, but specifically, furthering our efforts to help States provide long-term care in the least restrictive setting possible, and strengthening consumer protections for those who do purchase long-term care insurance.

Again, I look forward to today's witnesses and discussion, and thank the witnesses for their testimony and their patience.

Mr. DEAL. The Chair recognizes the chairman of the full committee, Mr. Barton, for an opening statement.

Chairman BARTON. Well, thank you, Mr. Chairman, for holding this hearing. I think this is one of the critical hearings we are going to have in this subcommittee this year. I want to thank our two witnesses that are here before us, and then the panelists that are on the next panel.

I just met with the five Directors of the Children's Hospitals in Texas, one in San Antonio, one in Houston, one in Dallas, one in Fort Worth, and one down in the Valley. And they all told me that 70 percent of their patient load is paid by Medicaid. These are our children. Medicaid was set up 30, 35 years ago to take care of low income, indigent healthcare for our population, but what has happened is it has become a surrogate for long-term care for our seniors. Two-thirds of our dollars in Medicaid are going for long-term healthcare in nursing homes, which means the group that I just met with are having to scramble to fund care for our younger low income and indigent population, and if we don't take care of them at that age, they become a bigger and bigger burden as they progress, as they grow up.

So this hearing today is to try to see if there is not some way to at least begin a dialog about long-term healthcare, and find out if there is not some way to take it off the backs, or at least relieve the burden on Medicaid, so we free up dollars to help the people that I was just visiting with from the Children's Hospitals of Texas. This country has not wanted to address the issue of long-term healthcare. The last time we talked about it on the floor of the House, I believe Claude Pepper of Florida was still chairman of the Rules Committee, and he actually brought to the floor a long-term

healthcare bill, and we may have even implemented it briefly and then repealed it. I could be corrected on that if that didn't happen.

So this is the beginning of a dialog in the House, at least, on the substance of long-term healthcare, which means Medicaid reform, and I hope some time this summer, we can find some consensus and decide to do more than hold a hearing, because it is very, very important. And I am going to close, Mr. Chairman, with reading a paragraph from the committee staff memo that was put out for this hearing. It says: "Long-term care is one of the most significant demographic and physical challenges of this century, and of particular importance because of our rapidly aging population. In 2000, there were an estimated 9.5 million people with long-term care needs in the U.S., including 6 million elderly and 3.5 million non-elderly. These numbers are projected to grow dramatically in the coming years, especially after 2030, when the baby boom generation begins to reach 85." Just parenthetically, I will be 80, if I am lucky enough to be alive in 2030. "The senior population, 12.6 percent in 2000, is projected to rise to 20.5 percent by 2040. The fastest growing share, 85 plus, is projected to rise from 1.6 percent to 3.8 percent. This population, which is most likely to need long-term care, is projected to more than triple from 4 million to 14 million nationally."

So it is very important, Mr. Chairman, that we begin this dialog, and hopefully find some consensus on solutions to it. And again, I want to thank you for the hearing, and I want to thank our two witnesses before us right now, and then the panelists on the second panel.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Deal, for holding this important hearing today. I also want to thank all of our witnesses for their testimony, which will provide valuable perspectives on the crisis facing long-term care financing.

I begin with a quote: "Although Medicaid was originally designed to provide health care to low-income women and children, it has become our country's "de facto" payer of long-term care for the elderly and disabled... The unsettling notion here is that we have no real, comprehensive long-term care system in this country and yet we are spending billions of dollars for a system that was not designed—it just evolved. Unfortunately, the system we have is inefficient, outdated, incomplete and unable to meet the needs of current or future recipients. Simply stated, this is an issue that just can't wait."

I'd like to take credit for such astute observations, but credit goes to Sen. John Breaux who made this statement more than three years ago as Chairman of the Senate Special Committee on Aging. His call to action was timely then and critical now.

Public spending on long-term care and Medicaid generally is growing at an unsustainable rate. There just are not enough taxes or taxpayers to keep it going without bankrupting the budgets of working families, not to mention the national economy. Medicaid is already the biggest item in state budgets, exceeding elementary and secondary education combined. Unreformed, analysts predict Medicaid will bankrupt every state in as little as 20 years—absorbing 80-100% of all state dollars.

At the moment, Medicaid accounts for more than 40% of total long-term care spending and nearly half of spending for institutional care. Medicaid long-term care costs account for one-third to one-half of total Medicaid expenditures in most states and about half of Medicaid long-term care spending is for the elderly.

The senior population—12.6% in 2000—is predicted to rise to 20.5% by 2040; the fastest growing share, 85+ ("the oldest old") is projected to rise from 1.6% in 2000 to 3.8% in 2040: this is a 42% increase in the population most likely to need long-term care.

We need to understand the relationship between the availability of Medicaid and long-term care planning: Why do so few people plan ahead if long-term care costs can be so devastating and Medicaid is a welfare program meant only for the poorest among us? We need to learn what can be done promote greater accountability and encourage individuals with sufficient resources to take responsibility for planning for their future health care needs. I look forward to hearing our witnesses' opinions on these important questions.

It is also clear that current efforts aimed at estate recovery neither encourage long-term care planning nor result in appreciable recovery of funds for Medicaid. We may need to look at making changes to the rules created under OBRA '93, but rarely enforced by states, to impose consequences on states that fail to comply with these requirements. We also need to examine new ways to bring home equity into the financing equation on the front-end—to forestall or at least minimize reliance on public funding.

In the final analysis, Comptroller General David Walker got it right when he testified in 2002: "Only if the limits of public support are clear will individuals likely take steps to prepare for a possible disability." We have not done a very good job at making this distinction and the public should not be faulted for responding rationally to the complex and confusing financing structure that we allowed to develop. We must provide clarity before the care needs of 77 million baby-boomers overwhelm our ability to provide a safety net for the truly needy—for whom Medicaid was originally intended.

There are serious challenges facing Medicaid today, long-term care financing among them, and the program is clearly at a crossroads. I hope some of the suggestions our witnesses offer today will help the Committee as we plan to move forward with Medicaid reform. We need to look for innovative bipartisan solutions for the problems facing Medicaid in order to strengthen and improve the program. Medicaid beneficiaries deserve nothing less. So do America's taxpayers.

Mr. DEAL. I thank the Chairman. The Chair recognizes Ms. Capps for an opening statement.

Ms. CAPPS. Thank you, Mr. Chairman. As we can tell from the opening statements, most of us agree that the growing cost of long-term care in Medicaid is a rising challenge. And thank you for being here for the hearing, those of you who are presenting. We should be looking at some of the various ideas out there to improve long-term care and sustain Medicaid support for it.

I believe we need to be careful that we do not too hastily embrace proposals which would harm those who need care or waste taxpayer dollars, and we should also be careful not to jump to conclusions that are not supported by evidence. Many proponents of change claim that wealthy seniors in large numbers are gaming the system and stealing from Medicaid. They argue that we must make dramatic changes to asset transfer limits in order to cut back on these practices. But there is, to my knowledge, nothing but anecdotal information to support these claims.

GAO has reviewed this issue twice since 1993, and found little evidence to support it, and the proposals they have put forward might catch some people who are, indeed, inappropriately receiving benefits, but they would certainly deny care to many elderly or disabled Americans who are impoverished, who desperately need and depend upon coverage. This would certainly save the Federal Government money, but at what cost to families struggling to support loved ones who need long-term care? We should measure the cost of this effect on families, on wage earners who must stop working in order to care for elderly and other, and on and on.

Perhaps there is evidence out there, but it should be produced before we make drastic changes, and the changes we make should fit the problem. Some people are expressing interest in expanding the use of long-term care insurance. That approach might have

some merit, but there are some pitfalls we must avoid as well. There must be adequate consumer protections put in place to ensure that the elderly and disabled are not abused, and real savings to Medicaid needs to be demonstrated. CBO estimates that expanding the current long-term care partnership program would end up costing the Federal Government \$45 million over 10 years. Frankly, any savings that were derived would probably not materialize for decades, since the purchasers of long-term care insurance won't need coverage until they are much older. I am not saying that we shouldn't do this, but we should be aware of what we are getting into when we do.

Finally, I will say I am pleased with the administration's attention to encouraging community-based care for the elderly and disabled. When you see bright spots of this kind of continuity of care of communities, you realize that this is certainly our goal, to have it be seamless across the Nation. But the attention that the administration is giving is at odds with the billions of dollars in cuts that are being asked for in the budget. Community care, when possible, is far better for beneficiaries than being in an institution, but sometimes it costs more, and cutting Medicaid now will only stifle efforts in this direction.

For example, my colleague from Nebraska, Mr. Terry, and I have introduced legislation to increase wages for direct support personnel under Medicaid, sorely needed, but the obstacles facing this bill right now, and other improvements to Medicaid, are going to be made all the more difficult by the cuts the budget that we just voted for, the vote that we took yesterday in the House, from the budget framework. So we have our challenges now, and I hope that we can find ways to truly improve Medicaid, and not resorting to the arbitrary cuts.

I yield back the balance of my time.

Mr. DEAL. The gentlelady's time has expired. Mr. Gillmor. Any one on the majority side wish to make an opening statement? Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. I do want to make an opening statement. I want to thank you for holding this hearing, and I want to thank our witnesses, both on this panel and on the subsequent panel.

As a number of our colleagues have correctly pointed out, both long-term care and Medicaid pose significant demographic and important fiscal challenges to us as a Nation. It is important that we examine those challenges, and that we address them in a way that best serves all Americans.

It is our responsibility to make sure that Medicaid works and provides both quality care and does so at a reasonable expense. In this regard, I am pleased to highlight a model that we should at least be looking at, because I believe it can work. Arizona has been a pioneer in this area. More than 20 years ago, my State embraced the Federal waiver process to create a viable alternative to traditional Medicaid. It created what is called the Arizona Health Care Cost Containment System, AHCCCS, which has been recognized for its success in providing high quality medical care and also controlling costs. Building off the AHCCCS program, we also, in 1988, created the Arizona Long Term Care System, which currently en-

rolls more than 40,000 individuals, and greater than 90 percent of those individuals report either being satisfied or very satisfied with the care that they are getting.

I believe that the success of both of these programs, AHCCCS and ALTCS, is in part due to their flexibility, and in part due to the benefits they provide. Individuals can choose a service provider, which then works with them to select the level of service needed, and importantly, the setting in which that service will be provided, including home-based care. Regular monitor, case management, and member satisfaction surveys are critical components of this system. In addition to being supported by the enrollees, the program has achieved substantial savings. A CMS study evaluated the program and determined that the Arizona system had saved 16 percent of the costs that would have been incurred if Arizona's program had been traditional Medicaid. Another study found that the Arizona model provided savings equal to roughly 35 percent of nursing home costs that would have been incurred without the program.

I think it is important that we remember there are examples out there where we can produce both quality care and savings, and I compliment you, Mr. Chairman, on holding these hearings. I encourage the committee to look at the Arizona model, not necessarily as perfect, but as at least one which sets the goal of both maintaining and actually vastly improving the quality of the system, while also achieving savings. And with that, Mr. Chairman, I yield back.

Mr. DEAL. I thank the gentleman. Mr. Rush.

Mr. RUSH. Thank you, Mr. Chairman, and I also want to welcome both the witnesses on this panel and the following panel.

Mr. Chairman, I must start off by saying that I disagree with the premise of this hearing. The Medicaid program does not need the types of "reforms" many of the detractors of the program would suggest. Why is it that Medicaid needs—what Medicaid needs is the political will of this Congress to step up to the plate and fund a vital safety net program that cares for our most vulnerable population.

Mr. Chairman, why is it that this Congress only has a taste for reform when it involves programs for the poor, the disabled, and the elderly? Why is this Congress' zeal—where is this Congress' zeal when it comes to spiraling drug costs, or when it comes to the spiraling budget score of the recently passed Medicare prescription drug bill? Why don't we call for reform in the spiraling taxpayer subsidies to corporate interests in our recently passed Energy Bill, of course, which I voted for.

Why doesn't this Congress take on reform when it comes to the escalating costs in the occupation of Iraq, or our tax code where corporations hide their funds in overseas tax shelters? It seems that this Congress is very selective in its zeal for reform, and it is always reserved for matters affecting the poor and the vulnerable.

Having said that, I want to further highlight a particular reform that I find to be completely outrageous and a blatant attack on working class and middle class families, and that is requiring them to take out reverse mortgages in order to pay for their long-term healthcare costs. The House of Representatives just passed a bill that repeals the estate tax to the benefit of the very wealthiest

Americans. Proponents of this repeal argue that no matter how rich you are, your assets should automatically be passed on as you see fit without giving one cent to the Federal Government. Working class and middle families did not benefit from this repeal at all, because their assets have never met the threshold of the estate tax. It is bad enough that these families did not benefit from this repeal, but now, we have proposals floating around that will require or encourage them to actually liquidate and use up the only asset that they have, and that is their home.

The reason for this convoluted version of class warfare, well, because Congress doesn't want Medicaid to pay for their long-term care. They want working and middle class citizens to pay themselves with literally their only asset, their homes. It is an absurd proposition, and it is unconscionable.

Mr. Chairman, I am not an ideologue. I am a pragmatist and I am a humanist, and I am tired of hearing about proposal after proposal that only targets the most vulnerable members of our society. I am tired of calls for reform that fall squarely on the shoulders of many of my constituents. It is my hope that we want to control costs and institute meaningful reforms, and this committee will look elsewhere.

Thank you, and I yield back the balance of my time.

Mr. DEAL. The Chair would ask unanimous consent that Ms. Wilson, a member of the full committee, be allowed to participate with an opening statement, and in questioning, following members of the subcommittee. Without objection, so ordered. Anyone else on the majority side wish to make an opening statement? Anyone on the majority side? If not, I will go to Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I would like to welcome Dr. McClellan. As Congressman Waxman said, our pair of docs are here, but again, those of us who are from Texas who live in Washington a lot of time kind of get homesick every once in a while. I hope you get to go home.

Mr. Chairman, I want to thank you and our ranking member for holding this hearing on long-term care and Medicaid. The hearing coincides with what may be happening this week on the Budget Committee negotiations about the level of the Medicaid cuts that will be included in the budget conference report. Since it is one of our first hearings on the Medicaid issue, I want to express my opposition to any legislative attempts to balance the budget on the backs of the Medicaid program. Medicaid is not the source of our budget problem. Medicaid is not the driving force behind the increasing healthcare costs in our country.

Just to put the program's costs in perspective, between 2000 and 2004, employer-sponsored health insurance premiums rose 12.6 percent. Medicare's costs rose 7.1. During that same time, Medicaid's cost grew only 4.5, despite the fact that Medicaid witnessed a 23 percent increase in its beneficiary population. If Congress is going to deal with our country's budget problems, it shouldn't do so by placing a bulls-eye on the back of the Medicaid program, which has kept cost growth remarkably low despite a tremendous increase in demand.

Ultimately, our committee will be charged with finding the cuts in Medicaid, as outlined in the final budget resolution, which is

why it is important for us to have an in-depth examination of the aspects of the Medicaid program. I appreciate our witnesses coming to testify today, both our first panel and the second panel, and look forward to their recommendations on long-term care policies. In my home State of Texas, one in nine Texans are on Medicaid. Under the President's budget, Texas would lose \$2.4 billion over 10 years in Federal Medicaid contributions, the third largest loss by a State following New York and California. A cut this large puts our States in a no-win situation, forcing them to make painful cuts to optional Medicaid services. And Texas, again, doesn't participate in a lot of the optional Medicaid services. With 90 percent of the Medicaid long-term care spending considered optional, the accessibility and quality of long-term care will surely decline under these cuts, and contribute to the tremendous suffering among our vulnerable populations.

Again, Mr. Chairman, I am glad we are holding our first hearing, and if we are going to get the marching orders, I would hope we would look at it very judiciously on where we are going to cut the programs in Medicaid. And I share the Chairman's concern about our children's hospitals, but I also know that Medicaid has not been the big cost increase that we have seen, and I will yield back my time.

Mr. DEAL. Anyone else wish to make an opening statement? Ms. Wilson.

Ms. WILSON. Thank you, Mr. Chairman. Thank you for holding this hearing, and thank you for graciously allowing me to participate as well. I think that long-term care is the biggest challenge that we face in Medicaid, and it is a challenge today, but it is even more of a challenge in the future, when we see our population age.

Medicaid and long-term care in Medicaid covers a variety of populations. It is not only seniors. It is the adult disabled, and it is medically fragile children in our foster care systems. And it is an extremely important safety net for many Americans. There is, within Medicaid, a prejudice toward institutional care, when none of us want to spend our days in an institution if we can stay at home, and yet, Medicaid favors that kind of care, and in many cases, you need an exception to the Federal rules to stay at home rather than go to a nursing home. Seventy percent of our nursing home beds are paid for by Medicaid, and our insurance on long-term care insurance policies and laws are not aligned with statutes on Medicaid. It is very hard to encourage somebody, to convince somebody they should buy something like long-term care insurance, when they can get it for free. We need to align these policies, and long-term care in Medicaid is in need of reform.

At the same time, we underpay for the quality of care we want our parents to have in Medicaid, and shift the costs to others, and encourage nursing homes, or look the other way when they cut corners, because we are not paying for the quality that we demand on the regulatory side. All of us in this room know, and most of us who have listened to radio or television also know that there is a subspecialty of the bar on how to divest yourself of your assets and qualify for Medicaid, how to protect your kids' inheritance and still get the nursing home coverage paid for.

We cannot afford for middle and upper income Americans to give away their assets while we are underpaying for the quality of care that low income Americans deserve. That is why this system needs reform. I think we need a national strategy on long-term care, particularly for seniors, that aligns our policies on insurance and in the tax code with what we do on Medicaid.

We also have to include a component of education, so that people understand the potential and the cost of long-term care. Most Americans, I think, figure that—think that Medicare will cover them in a nursing home, and it doesn't for long-term care, and we need to dispel those misperceptions. I think we need a national strategy on long-term care. I expect to be introducing some legislation in this area, but I also think we need broader consensus, which is why I have proposed a national commission to address and give us some big ideas for how we can address this, both at a Federal level and integrated with State policy.

And again, Mr. Chairman, thank you for allowing me to participate.

Mr. DEAL. I believe that concludes our opening statements.
[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. PAUL E. GILLMOR, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF OHIO

Thank you, Mr. Chairman for holding this important hearing.

With a generation of baby boomers growing older, life expectancy on the rise, a shrinking labor force, and smaller family units, the demand for long-term care is likely to increase, producing an even further strain on our nation's Medicaid program. Absent future demographic realities, there no question that Medicaid is in dire need of transformation now.

Today, it is safe to say that a majority of states are experiencing skyrocketing Medicaid costs coupled with declining revenues. I think that we can also agree that long-term care services represent a lion-share of these costs.

In my home state of Ohio, despite recognizing the reality of a broken system and enacting a number aggressive cost containment and budget strategies, Medicaid expenditures are increasing at twice the rate of growth of state revenues, amounting to a total \$10.5 billion. This figure represents over 40% of the state's general revenue fund spending and is larger than Ohio's entire state budget in 1987.

Furthermore, Ohio's long-term care consumers comprise 24% of the entire population served by the state's Medicaid program, yet they gobble-up 74% of the Medicaid spending.

In response, the Ohio Commission to Reform Medicaid was formulated in December 2003, and earlier this January, they released their recommendations. I applaud Ohio's efforts, and would bring the public's attention to its four primary long-term care recommendations:

Ensure access to a wide array of long-term care service and financing options in home and community-based settings or in institutions.

Ensure that the elderly and disabled, their families and/or caregivers have easy, immediate access to a full range of cost-effective options and needed information about long-term-care options, especially in a crisis situation.

Encourage personal choice and responsibility for long-term care by modifying estate and asset recovery, as well as state funding policy.

Create a cost-efficient long-term care system with consolidated budgets, data collection and planning.

With the evolution of Medicaid over the years, reform ideas have come and passed, or simply been swept under the rug. We must take hold of today's circumstances and remain committed with our governors to transforming our system into one of personal responsibility, quality and efficiency, for our citizens that need it the most. I welcome the well-balanced panel of witnesses, look forward to their testimony, again thank the Chairman, and yield back the remainder of my time.

Mr. DEAL. Gentlemen, we are pleased to have both of you here today, and Dr. McClellan, the Administrator of CMS, I will recognize you for 5 minutes for your remarks.

STATEMENTS OF MARK B. MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND DOUGLAS HOLTZ-EAKIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. MCCLELLAN. Thank you, Chairman Deal, Congressman Brown.

It is a privilege to be here this morning to talk about long-term care and the need for transformation of the Medicaid program. Medicaid is the largest source of public funding for long-term care in the country. It is and must remain an essential lifeline for the most vulnerable Americans, but that lifeline is threatened, and it is falling behind today.

We must ensure that those who need Medicaid assistance with long-term care services are protected by benefits that reflect the best and latest evidence on how to get quality results in long-term care. At the same time, we must also encourage and support those who are capable of paying for their own care to plan ahead, so they can maintain control without requiring substantial public funding.

And I would like to say a little bit more about both of these goals. As you all have pointed out, State and Federal financing of long-term care is growing rapidly, and it is a significant challenge as our population ages. At the same time, long-term care has been changing, but Medicaid has not kept up. As you all have said, Medicaid needs to keep pace with the growing long-term care needs of the aging population that wants to remain as active and engaged as possible, and increasingly can do so. Institutional care remains an essential part of long-term care today, and it can be the best approach for people with a disability who can't be cared for safely and effectively in other settings. Indeed, we have seen important innovations in nursing home care, and improvements in quality in recent years, as part of our Nursing Home Quality Initiative, which involves collaboration with States and consumer advocates in the nursing home industry.

But Medicaid was designed at a time when long-term care was very different than it is or should be today. When Medicaid started in 1965, long-term care generally meant institutional care, and so a nursing home benefit was, and continues to be, a mandatory benefit under Medicaid. But thanks to progress and the support of technology, and good ideas on how to support people with a disability, long-term care has changed substantially, so that many types of services can be provided as effectively or more effectively, and at the same or lower cost in a beneficiary's home or community.

You can think about it this way: If Congress were to create the Medicaid program in 2005, you would have to get a waiver and go through extensive regulatory hurdles if a State wanted to provide a benefit with institutional care only. It is time to update the Medicaid program to reflect this reality. It is time to end the institutional bias in the Medicaid statute by giving beneficiaries the con-

trol they deserve, and to enable Medicaid to serve more people without spending more money.

Because Medicaid has not kept up with the progress in long-term care, most Medicaid beneficiaries today don't have the opportunity to choose how and where they want to receive long-term care services. We can't afford to do this any more, either from the standpoint of quality long-term care or from the standpoint of cost. Beneficiary control means better quality and more people served for the same or lower cost.

In its current form, though, the Medicaid program doesn't allow such flexibility. States have the option to provide home and community-based services through waivers, but they are not required to do so, and in fact, they have to go through a process to provide these services. As a result, there is an institutional bias that many Medicaid programs have that often keeps Medicaid beneficiaries from choosing how to get their support. We have made progress to address this with the President's New Freedom Initiative, and it is time to take further steps.

The administration's budget includes a package of six New Freedom Initiative proposals, including the centerpiece of our community-based proposals, Money Follows the Person. That is our Medicaid strategy. We want more money going to where it can make the most difference, redirecting it. That is what our budget proposals are all about, not about cuts. It is about putting the money where it can make the most difference. The Money Follows the Person initiative authorizes \$350 million in each of 5 years for a total of \$1.75 billion.

Several States have already implemented similar programs. We have heard from members in Texas. We heard about the program in Arizona, mentioned by Congressman Shadegg. These programs save money. They increase quality. They get more people into the community. We also need to improve the financing of long-term care and encourage Americans to plan for their future. To make sure Medicaid remains secure and sustainable, we need to take steps to help individuals who can contribute to their long-term care costs to do so, and then, we need to concentrate our Medicaid funds on people who have no alternatives.

Our budget proposal to reform transfer of asset requirements is one part of this process. At the same time, we also need to help individuals take more control of their long-term care needs when they have the means to do so, through options like long-term care insurance and reverse mortgages. The Partnership for Long-Term Care, which is available in four States, is a joint venture between Medicaid and long-term care insurers to create affordable products that encourage people to self-insure and protect a substantial portion of their assets at the same time. It gives individuals full control over how they receive long-term care services, and that reduces costs for the Medicaid program.

This program works. In the partnership States, people who purchase long-term care insurance almost never end up needing Medicaid assistance for long-term care costs. We also need to encourage people to learn about reverse mortgages, which will allow homeowners to convert a portion of their equity in their home into financial support for long-term care services where they want them, in-

cluding in their home. We need to encourage them to learn about it. That is not the same thing as a requirement.

Medicaid's current system of covering long-term care is out of date, yet it is one of the largest and fastest-growing sources of funding for long-term care for the elderly and people with a disability. That is not a sustainable combination. We are at a crossroads. To improve quality in Medicaid, to help Medicaid dollars go further, we need to give people with a disability control of their long-term care services, in Medicaid and through private sources of financial support.

Mr. Chairman, we look forward to working with you to strengthen Medicaid and enable the program to provide better support for the millions of Americans who count on it, and I want to apologize for the statement getting to you late last night. I would like that written statement read into the record, along with my remarks. This is an especially important issue, about which we have been talking to you and your staffs, and I was especially encouraged by the statements from both Republicans and Democrats this morning, that there is a real opportunity to get an agreement on improving Medicaid and the way it supports long-term care. So we absolutely want to be closely engaged with you on this critical issue this year.

[The prepared statement of Mark B. McClellan follows:]

PREPARED STATEMENT OF MARK B. MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

INTRODUCTION

Chairman Deal, Congressman Brown, distinguished members of the subcommittee, thank you for inviting me here today to discuss long-term care and the need for transformation in the Medicaid program. There are a number of public programs that play a role in our long-term care system. Medicare plays a major role, but Medicaid is the largest public source of funding for long-term care in the United States. It is, and must remain, an essential lifeline for the most vulnerable Americans. In 2000, Medicaid paid for 45 percent of the total amount spent on long-term care services in the United States. State and federal financing of long-term care costs is a significant issue both for state and federal budgets. In FY 2004, total federal and state Medicaid expenditures on all long-term care reached \$100.5 billion and accounted for 35.7 percent of all Medicaid spending.

Spending by the federal government and states for long-term care services through Medicaid has been growing rapidly. This growth in long-term care expenditures will continue to increase as our population ages. At the same time, Medicaid needs to keep pace with the long-term care needs of an aging population that wants to remain as active and engaged as possible. Medicaid should ensure that people with a disability are able to contribute to society to the greatest extent possible. With the growing demands on Medicaid, we cannot afford to wait to take steps that contribute both toward improved quality of life for more people with a disability and toward the long-term viability of the program. It is critical for us to respond to these challenges by ensuring that those who cannot afford to pay for long-term care services are protected by benefits that reflect the best and latest evidence on how to get quality results in long-term care, while encouraging and supporting those who are capable of paying for their own care to plan for their future in a manner that gives them control and does not require substantial public funding.

For all of these reasons, it is critical to give Medicaid beneficiaries and their family members and caregivers more control over how they get their care. As I will describe in more detail, properly done, beneficiary control means better quality and more people served for the same or lower cost. In its current form, however, the Medicaid program does not generally allow such flexibility. Reflecting the delivery of long-term care in institutions when the Medicaid statute was enacted in the 1960s, the Medicaid program does not rely on the community-based long-term care that best meets beneficiaries' needs. Long-term care in 1965 was centered on institutions, while today it should be focused more on the person and the supports and

services the person needs. Care in a nursing home is the best option and the preferred option for many Medicaid beneficiaries, especially with recent quality improvement initiatives undertaken by many nursing homes. But progress over the last several decades in supportive technologies and ideas for supportive care means that the decision about how to receive long-term care services should be a personalized decision for the beneficiary. Because the Medicaid program has not kept up with progress in long-term care, thousands of Medicaid beneficiaries today do not have the opportunity to choose the most appropriate place for receiving long-term care services. It is time to give beneficiaries the control they deserve to enable Medicaid to get much better value for its money.

Medicaid is Currently the Primary Public Program for Financing Long-Term Care

For beneficiaries in the Medicaid program, most of their long-term care services, including medical and non-medical care, are provided by Medicaid. Most long-term care is intended to assist individuals with activities of daily living, such as getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, such as using eye drops or oxygen, and taking care of colostomy or bladder catheters. These services may be provided in either institutional or community-based settings.

Unlike Medicaid, Medicare does not cover most long-term care services. Medicare pays only for medically necessary skilled care in a nursing facility or home that is needed to treat, manage, observe, and evaluate care. Generally, under Medicare, post-acute skilled care is available only for a short time after a hospitalization and beneficiaries must meet certain conditions for Medicare to pay. Examples of skilled care include intravenous injections and physical therapy. Medicare skilled nursing care and home health aide services are only covered on a part-time or “intermittent” basis as part of the home-health benefit.

Eligibility for Medicaid Long-Term Care Varies by State

States have considerable discretion in determining who their Medicaid programs cover and the financial criteria for Medicaid eligibility. As a result, income and asset eligibility tests vary by state. However, to be eligible for matching federal funds, states are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for certain related groups not receiving cash payments. States also have the option of providing Medicaid coverage for other “categorically needy” and “medically needy” individuals. The medically needy option allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups, but have significant medical expenses. The medically needy option allows individuals to “spend down” to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State’s Medicaid plan.

Medicaid Coverage of Long-Term Care is Out of Date

When Medicaid started in 1965, institutional care was the norm for long-term care services; thus, a nursing home benefit was and continues to be a mandatory benefit that states must provide. States have the option to provide home- and community-based services through waivers, but they must develop and submit a waiver, and obtain support in the state for the waiver implementation, in order to provide these services. As a result, there is an institutional bias in many Medicaid programs that often keeps Medicaid beneficiaries from choosing where they receive long-term care support and services. Institutional care remains an essential part of long-term care today and may be the best approach for a portion of the elderly and individuals with disabilities who cannot safely be cared for in other settings, especially with the improvements in quality and capability that have occurred in recent years in many nursing homes. Those individuals who need the specific types of medically intensive, skilled services nursing homes provide, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide such care reliably and with consistently high quality. For this reason, to help beneficiaries who need nursing home services get better care CMS has undertaken some major quality reporting and quality improvement initiatives, which are discussed later in this testimony.

Today, however, institutional care is only one part of a range of long-term care options that should be available to Medicaid beneficiaries. This is especially urgent because so many Medicaid beneficiaries would prefer to receive their long-term care supports and services in home- or community-based settings. Not all individuals currently cared for in nursing homes need or want that type of institutional care. In spite of the bias in the Medicaid statute, we have worked hard with advocacy

groups, states, and our other partners to expand consumer options with regard to home- and community-based services. The key concepts here are consumer choice and control. By working to give individuals choice and control over supportive services in the community, the home- and community-based waivers that we have implemented in some states have simultaneously increased personal autonomy while promoting better decision-making about supports and services. These programs have shown that, often, the most cost-effective place to provide care is where most people would prefer to receive their care: living in their homes, connected to their communities, surrounded by friends and family. And that means better outcomes without higher costs in Medicaid—a result that we cannot afford to pass up any longer.

Medicaid's Long-Term Care System Must Change

Mr. Chairman, to ensure Medicaid can serve more beneficiaries at a lower cost, the institutional bias in Medicaid long-term benefits resulting from lack of beneficiary control must be addressed. CMS has been working hard to promote consumer choice and home- and community-based services over institutional care when it is appropriate for beneficiaries. Both consumers and states are very receptive to this approach, and the evidence from the programs developed so far is that it is a win-win effort.

The progress we have made with the President's New Freedom Initiative (NFI) points us in the right direction. We have undertaken a number of efforts to rethink, redesign, and re-balance a program that has traditionally been institutionally biased. The President's FY 2006 Budget includes NFI legislative proposals to make this happen. The President's Budget requests \$385 million in budget authority for FY 2006 and \$2.2 billion in budget authority for the five-year budget window. We made inroads with this legislation in Congress last year, and this year we want to work with Congress to go further and enact the proposed legislation.

Medicaid Proposals in the President's Budget Would Improve Long-term Care Services

CMS plays a unique role in identifying and supporting effective, innovative state Medicaid reforms that save money and maintain and, in some cases, substantially improve quality of care and quality of life. The President's FY 2006 budget includes several policies to promote home- and community-based care options. These policies, including the Money Follows the Person Demonstration, build on the President's New Freedom Initiative, which is part of a nationwide effort to integrate the elderly and people with disabilities more fully into society.

The New Freedom Initiative Promotes Independence and Choice

The President's New Freedom Initiative represents an important commitment toward ensuring that all Americans have the opportunity to develop skills, engage in productive work, choose where to live, and participate in community life. The President's Initiative, which we are working to implement throughout the government, is about the promise of *freedom* for every elder and person with a disability. It is a promise of independence, choice, and dignity. Our goal with our long-term care initiatives is to work with states to get to the point where consumer choice is the norm in our long-term care system—including in Medicaid. The budget includes a package of six New Freedom Initiative legislative proposals, including the centerpiece of our community-based proposals, Money Follows the Person, which promote home- and community-based care options for elders and people with disabilities.

Money Follows the Person Promotes Community-Based Living

As part of the New Freedom Initiative legislative package, the President's FY 2006 budget authorizes \$350 million in each of five years, a total of \$1.75 billion over five years, for the Money Follows the Person demonstration. In the initiative, the federal government will pay the full first-year cost, with no state match required, for a package of home- and community-based services for eligible individuals who move from institutions into the community and after the first year costs will be shared with the states at the existing Federal Medical Assistance Percentage (FMAP) rate. This will assist states in their efforts to reorganize and rebalance their long-term care service and support programs and integrate this demonstration into the Medicaid program. We believe individuals and families make better decisions for themselves than the current institutional-based, provider-driven systems.

While states are making efforts to develop infrastructures designed to support community-based services, progress in reducing dependence on institutional care has been difficult to achieve due to the fiscal challenges states are facing. The initiative will help states achieve a more effective balance between the proportion of total Medicaid spending on institutional services and the proportion of funds used for community-based support in their state plans and waivers. States will be encour-

aged to develop and adopt a coherent strategy for reducing reliance on institutional care. The initiative also will help states design flexible financing systems for long-term services and supports that allow funds to move with the individual beneficiary's preferences to the most appropriate and preferred setting as the individual's needs and preferences change.

Earlier we said the 100 percent FMAP assists states. Again, for individuals who move voluntarily from a Medicaid-certified institution to the community, in this five-year demonstration project, the Federal government will fully reimburse states for one year of home- and community-based Medicaid services for such individuals. At a minimum, the package of services available in the community must be equivalent to the services that a state could provide under a Medicaid waiver. After the initial year, a state will be reimbursed by the Federal government for services provided at FMAP rates. States must commit to serve Medicaid eligible demonstration participants for as long as they need home- and community-based services.

CMS is one of five sponsors for the HCBS clearinghouse website for the Community Living Exchange Collaborative. The clearinghouse is intended to facilitate sharing information, tools, and practical resources across states and local entities based on information from grantees, states, academic institutions and others. For example, Medstat, a contributor to HCBS.org, highlighted several promising practices in the Money Follows the Person initiative, including those discussed below. As a result of the Real Choice Systems Change grants, states have made steps in making home- and community-based services available to individuals, and the following state examples illustrate the progress we have made.

Texas—The Texas legislature added Rider 37 to the two-year state appropriations act that took effect in September, 2001. This rider allows the Texas Department of Human Services (TDHS) to move Medicaid funding from its nursing facility budget to its budget for state and Medicaid-funded home and community-based services (HCBS) when a Medicaid participant transitions from a nursing facility into a community-based residence. Any Medicaid nursing facility resident may apply for transition into the community and immediately use community supports, rather than be placed on a waiting list as was required before the rider. Each month TDHS identifies people who left nursing homes using the rider and estimates the cost of their community services for the rest of the fiscal year. TDHS moves the cost of the community services from the nursing home budget to the community supports budget. Over 1,900 Medicaid participants in Texas have transitioned from nursing facilities into the community under Rider 37. The Texas legislature extended the rider for a second biennial budget (until August, 2005).

Maine—To ensure people know about their options before entering a nursing home, Maine required pre-admission screening and periodic reassessment for all nursing home residents, regardless of the payment source. Maine also implemented a case-mix payment system for Medicaid nursing facilities and tighter Certificate of Need controls on nursing home growth. The state rapidly expanded HCBS options and encouraged development of more community residential care. Between 1995 and 2002, the number of Medicaid nursing home residents in Maine decreased 18 percent while the number of people receiving Medicaid and state-funded home and community-based services increased 78 percent. The proportion of state and Medicaid long-term support spent on HCBS increased from 16 to 39 percent. Total long-term care expenditures increased by only 17 percent over the seven-year period.

Indiana—In 2002, Indiana began an initiative to provide HCBS to people at imminent risk of nursing facility admission. Area Agency on Aging case managers work with hospital discharge planners to identify hospital patients who may be admitted to a nursing facility from the hospital. The case managers offer these people home and community-based services options. Some people use community supports immediately after their hospital discharge, while others use the services after a short nursing facility stay. Since 2002, Indiana has diverted 1,400 persons from institutional care.

Oregon, Washington, and Wisconsin—Oregon, Washington, and Wisconsin have taken a systems approach to rebalancing their long-term care systems and allowing the Medicaid funding to follow the person's preferences. These systems approaches to rebalancing combine legislative action, market-based approaches, and linkages. For example, Oregon and Washington established a single long-term care budget and Wisconsin passed legislation to create an entitlement to home- and community-based services in counties with the Family Care services benefit. In addition, these states made market-based changes (such as the institution of single point of entry and preadmission screening) to ensure that persons in need of long-term care are quickly identified, assessed, and informed of long-term options. In Oregon and Washington linkages were formed to merge administrative and regulatory responsibilities at the state and local level. In Wisconsin over half of the membership of

state and local governing councils and boards is held by program participants. As a result of these systemic changes, over half (57 percent) of Oregon's Medicaid long-term care spending for seniors and adults with physical disabilities is devoted to home- and community-based care. And in state fiscal year 2002, Washington served almost two and a half times as many participants in the community as they served in nursing facilities.

Home- and Community-Based Care Demonstrations Provide More Options

The FY 2006 budget includes proposals to encourage home- and community-based care for children and adults with disabilities, such as demonstrations to provide respite care for caregivers of adults and children. Another demonstration will evaluate the effectiveness of providing home- and community-based alternatives to psychiatric residential treatment for children enrolled in Medicaid.

Presumptive Eligibility will Help Beneficiaries in Transition

To reduce the prevalence of individuals entering nursing facilities from hospitals due to the length of time required to determine Medicaid eligibility for home- and community-based services, the President has proposed to offer states the option of providing those individuals who need Medicaid home- and community-based care with services for up to 90 days while Medicaid eligibility is being determined. Under this proposal, the Federal government will pay its share of the first 90 days of home- and community-based services whether or not the individual is ultimately deemed eligible for Medicaid.

Existing Initiatives Demonstrate Success of Home- and Community-based Long-Term Care

CMS is putting a lot of effort into identifying and supporting effective, innovative state Medicaid reforms that improve quality of care and quality of life for the same or lower Medicaid costs. It is the most effective way not only to make Medicaid sustainable, but also to improve the quality of life of our beneficiaries. There are several existing initiatives underway, which are helping the elderly and people with disabilities live meaningful, productive lives in the community, including the Real Choice System Change grants, Independence Plus Initiative, and home- and community-based waivers, all of which are discussed below.

Real Choice System Change Grants Foster Choice

While Real Choice System Change grants have provided much evidence of the success of home- and community-based services, it is time to shift resources and move ahead with more systematic, large-scale reforms such as the multibillion dollar Money Follows the Person initiatives in the FY 2006 Budget. We have learned much from the 238 grants in the Real Choice Systems Change grants program, totaling \$188 million, to help states and others develop programs that allow the elderly and individuals with disabilities to live meaningful, productive lives in the community. These grants are intended to foster the systemic changes necessary to allow elders and those with disabilities to access quality services from their choice of providers in accordance with their living preferences and priorities. Including the states we highlighted earlier as good examples for progress in Money Follows the Person activities, CMS has partnered with every state in the nation, the District of Columbia, and the U.S. territories to provide these grants from which we have developed new innovative ways to rebalance the Medicaid system. As shown in the state examples earlier, with this support, states are continuing to address issues such as personal assistance services, direct service worker shortages, transitions from institutions to the community, respite service for caregivers and family members, and better transportation options. CMS has also implemented an ambitious national technical assistance strategy, including the Community Living Exchange Collaborative mentioned earlier, to share information and support states' efforts to improve community-based service systems and enhance employment supports.

Independence Plus Initiative Increases Choice and Control

In 2002, CMS launched the Independence Plus Initiative to afford Medicaid participants increased choice and control that results in greater access to community living. Independence Plus is based on the experiences and lessons learned from states that have pioneered the philosophy of consumer directed care. The Initiative expedites the process for states to request waiver or demonstration projects that give individuals and their families' greater control over their own services and supports. Independence Plus programs not only deliver service in the community setting, but also allow a growing number of individuals and their families to decide how best to plan, obtain, and sustain the services that are best for them, giving beneficiaries the opportunity to control how they should receive the services they

need. The Independence Plus programs allow participants to design a package of individualized supports, identify and attain personal goals, and supervise and pay their caregivers. CMS has approved eleven Independence Plus waivers, including eight 1915 (c) IP waivers (New Hampshire, Louisiana, South Carolina, North Carolina (2), Maryland, Delaware, and Connecticut) and three "1115" IP waivers (California, and two others that are extensions of the original "cash and counseling" demonstration waivers in Florida and New Jersey).

Independence Plus programs have built on the very successful "Cash and Counseling" demonstrations. The Cash & Counseling Demonstration and Evaluation Program is a three-state experiment to determine the feasibility of offering a cash payment option in lieu of traditional agency services to recipients of personal assistance services. The demonstration enables people to hire whomever they want to provide their care by redirecting personal assistance funds to the consumers themselves (instead of to agencies). There are three original Cash and Counseling section 1115 demonstration programs (Arkansas, New Jersey, and Florida), two other states with section 1115 self-direction demonstrations similar to Cash and Counseling (Oregon and Colorado), and a multitude of states that offer self-directed program options under their section 1915(c) home and community based waivers.

Home- and Community-Based Waivers offer Alternatives to Institutional Care

Home- and community-based service (HCBS) waivers show that Medicaid can be an effective source of support for community living. Using HCBS waivers, states can provide alternatives to institutional care by allowing beneficiaries to live at home, where they can enjoy family, neighbors, and the comfort of familiar surroundings. States can only do this as long as the waiver remains budget neutral, meaning that the costs of providing services under the waiver do not exceed the costs that would be incurred if the services were provided in an institution.

Vermont and New Hampshire illustrate how institutional and home- and community-based care can lead to different results. Vermont has a highly developed home- and community based health care system. New Hampshire continues to rely on institutional care. In Vermont, 85 percent of the Medicaid population over age 65 still lives at home. In New Hampshire, only half can live at home. As a result, Vermont spends less than half as much per elderly person on Medicaid as New Hampshire, permitting more people to get the better results.

The trend towards home- and community-based care is rapidly increasing. The numbers tell the story very clearly: state and federal expenditures on long-term care have increased from \$13.9 billion in FY 2001 to an estimated \$20.7 billion in FY 2004. And over that period from 2001 to 2004, a total of \$68.7 billion has been spent to support home- and community-based waivers generally. More money has been spent in those four years than was spent during the previous eight years combined [\$56.6 billion]. Taking further steps to incorporate HCBS-based approaches into the Medicaid program will provide further momentum for this important trend.

Transition/Diversion Grants Awarded

When individuals try to move out of an institution for a more independent life, they may need assistance with certain one-time expenses, such as security deposits and essential household furnishings. In May 2002, CMS announced a clarification in policy to allow home- and community-based waivers to cover transition costs. In addition, CMS granted funds to states in support of these transition/diversion activities. To date, approximately 2,300 individuals have been transitioned from, or diverted from, nursing homes into the community with this grant assistance from CMS.

Resources and Support for Obtaining Effective Long-Term Care Services

CMS and the Administration on Aging (AoA) launched the Aging and Disability Resource Center (ADRC) Program in 2003. The Program provides competitive grants to states to assist them in developing and implementing "one stop shop" access to information and individualized advice on long-term support options, as well as streamlined eligibility determinations for all publicly funded programs. The long-range goal is to have ADRCs serve as "visible and trusted" places at the community level nationwide where people of any age, disability, or income can get information on all available long-term support options. The program also reduces government fragmentation, duplication, and inefficiencies. To date, 24 states have received grants to begin implementing ADRC pilots; another 18 to 20 states will receive grants in FY 2005.

Promoting Personal Responsibility and Planning for Long-Term Care Expenses

In addition to making more home- and community-based long-term care options available, we need to improve the financing of long-term care and encourage Americans to plan for their future. For Medicaid to remain sustainable for those who truly need it, we must ensure that Medicaid does not become an inheritance protection plan for those who can pay for their own long-term care. The CMS budget proposal to reform transfer of asset requirements is one part of this process. Furthermore, we also need to help individuals take advantage of private financing options to help pay for their long-term care, including long-term care insurance and reverse mortgages. Finally, support for education and planning about long-term care is needed, and CMS is working in conjunction with other components of HHS and other organizations to conduct outreach and to educate people about their long-term care options. CMS continues to work to identify ways to help people take more control of their future long-term care service and support needs, when they have the means to do so.

Reforming Transfer of Asset Requirements will Preserve Program Dollars for those in Need

The budget proposes to strengthen existing requirements for asset transfers as one element of a broader approach to promote personal responsibility and planning to meet long-term care expenses. To qualify for Medicaid long-term care services, an individual may only retain nominal assets. Current law requires individuals applying for Medicaid long-term care services to spend all but a minimum level of assets before becoming eligible. However, creative estate planning often allows individuals to become eligible for Medicaid legally, without spending their own available assets for needed care first. Several states are developing initiatives to curb this practice.

To help Medicaid funds go further for the beneficiaries who have no alternative source of support, the Administration's proposal would enable states to require more individuals to pay for some period of long-term care before Medicaid would pay the bill. This would be accomplished by changing the asset transfer penalty period. Currently, when an individual who applies for Medicaid has transferred assets at less than the fair market value within the three year look-back period, the amount of those assets are used to determine a period of ineligibility for long-term care services under Medicaid. However, the penalty period for such asset transfers currently begins on the date of the asset transfer. The result is that even for assets transferred within the look-back period, the penalty period is over before the individual requires long-term care services or applies for Medicaid.

This proposal would change the penalty period to the date when an individual is enrolled in Medicaid and is receiving long-term care services either in an institution or, in certain circumstances, in the community. This would make it less likely that individuals could plan ahead and transfer their assets, so that the penalty period expires prior to their needing long-term care.

Partnerships Instead of Asset Transfers for Sustainable Use of Long-Term Care

In effect, Medicaid today acts as a long-term care insurance policy for most people, not just those who lack the means to provide for their own long-term care needs. This is perhaps one reason that Medicaid coverage is often limited in quality and in scope: by providing access only to certain kinds of institutional care, for example, Medicaid may be used more as coverage of last resort. Although the specific coverage varies by state, Medicaid programs generally do not cover assisted living, and only some programs cover adult day care, both of which are coverage options in long-term care insurance policies. And as I have already discussed, many Medicaid programs limit coverage in the community. Supporting alternatives to Medicaid funding like long-term care insurance may consequently promote the availability of more community-based services in Medicaid. At a minimum, such steps would help make sure that more beneficiaries who really need Medicaid help would be able to obtain it. Long-term care insurance can help pay for a broad array of long-term medical and non-medical care, such as help with activities of daily living, that people with a disability often prefer to the limited Medicaid benefits.

The Partnership for Long-term Care is a very promising approach to this policy challenge, formulated to explore alternatives to current long-term care financing by blending public and private insurance. This blend provides an alternative to individuals either spending down all their assets or transferring all of their assets in order to qualify for Medicaid. The partnership between Medicaid and long-term care insurers is currently permitted to operate in only four states.

The four Partnership States—California, Connecticut, Indiana and New York—have focused on creating affordable products that encourage people to insure themselves for at least some of the long-term care costs they might incur, and that enable purchasers to obtain better protection against impoverishment, and that reduce long-term care costs for the Medicaid program. In these states, private insurance is used to cover the initial cost of long-term care. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria.

Although people in these states who buy long-term care insurance policies almost never have significant Medicaid spending, Congress has prohibited such Partnerships. The President's budget proposes to eliminate the current legislative prohibition on developing more Partnership programs.

Reverse Mortgages can Help Individuals Pay for Long-Term Care Expenditures

A reverse mortgage is a special type of home loan that lets an elderly homeowner convert a portion of the equity in his or her home into cash. The equity built up over years of home mortgage payments can be paid to the elderly homeowner. But unlike a traditional home equity loan or second mortgage, no repayment is required until the mortgagor(s) no longer uses the home as their principal residence. Funds obtained from reverse mortgages can be used by elderly home owners to pay for long-term care services and supports as well as other needs. It is estimated that forty-five percent of households at financial risk for "spending-down" to Medicaid could take advantage of a reverse mortgage to help them pay for long-term support. On average, these households could expect to get \$62,800 from a reverse mortgage. More widespread use of this financial option for long-term support services could potentially result in Medicaid savings.

The US Department of Housing and Urban Development's (HUD) Home Equity Conversion Program (HECM) of reverse mortgages provides these benefits. It is federally-insured by FHA and funded by lending institutions such as mortgage lenders, banks, credit unions, and savings and loan associations. To obtain a HECM reverse mortgage, an individual must be 62 years of age or older, own their home outright or have a low mortgage balance that can be paid off at the closing with proceeds from the reverse loan, and the home must be the individual's principal residence. The HECM reverse mortgage loan becomes due when the mortgagor dies (and there is no surviving mortgagor), the mortgagor sells the property, or the mortgagor no longer occupies the home as the principal residence.

Alternatively, an individual can obtain a reverse mortgage from the private reverse mortgage market. At the same time, such an individual can use the proceeds of the private reverse mortgage to buy a reverse annuity. This has the same requirements as a reverse mortgage. In such cases, when the individual sells his home, no longer lives in the home permanently, or dies, the individual or estate will have to repay the money received through the reverse mortgage (whether it was in the form of an annuity or otherwise), plus applicable interest and fees, from the proceeds of the home's sale.

CMS Is Expanding Efforts to Educate Americans About Long-Term Care Planning

Better understanding and support for long-term care planning can help lead to more private support and thus more Medicaid sustainability and personal control. To help provide this support, the Own Your Future Campaign was launched in 2004 to encourage more people to plan ahead for their long-term support needs. The project is a joint effort of CMS, AoA, the Assistant Secretary for Planning and Evaluation, the National Governors Association, and the National Conference of State Legislatures. It has been piloted in five states (Arkansas, Idaho, Nevada, New Jersey, and Virginia) and involves the use of various outreach techniques, including the targeted mailing of HHS materials and a letter from the Governor of each state to every household headed by an individual between the ages of 50 and 70. The letter includes a toll free number people can call to request a Long-Term Care Planning Tool Kit that covers a wide range of topics. Over 2 million letters have been mailed, and preliminary results within 3 months of the mailings showed about a 10 percent response rate—significantly higher than the 1 to 2 percent rate which is the norm for commercial marketing campaigns. We are encouraged by the early results of this campaign and will be conducting an evaluation of it to learn more about how best to provide this information.

Quality Improvements will Reduce Costs and Improve Outcomes

Providing better support for high quality, efficient providers is the best way—in fact, I think its the only way—to enable our beneficiaries to have access to modern medicine, to continue to get improvements in medical care and how it's provided,

while ensuring continued Medicaid coverage of long-term care whether these services are provided in the home or community or in an institutional setting.

Quality Care must be the Standard in HCBS Programs

The Administration has consistently worked to ensure that HCBS waiver programs allow people the independence to stay in their own homes while receiving quality care and support in a community setting. In the last three years, CMS has implemented a standard quality review protocol for regional office use in monitoring state programs; begun the first complete inventory of state HCBS quality assurance and improvement techniques; and begun developing a uniform national format describing key components of any quality assurance and improvement program for HCBS waivers.

CMS is working with the major state associations, including representatives of state agencies for developmental disabilities, head injuries, Medicaid, and aging, to assure all our forms and applications reflect our focus on quality in HCBS waivers. CMS developed a draft revised waiver application for all HCBS waivers, incorporating our quality expectations, and is also developing a new state annual report form to capture better information about states' quality management activities.

The Administration is committed to providing quality services in the home- and community-based setting and continues to engage in improving its role to ensure quality outcomes through federal and state monitoring.

Improving Quality in Nursing Homes is an Essential Part of Effective Long-Term Care Policies

Quality improvement also needs to extend to nursing facilities. We are working to improve quality while avoiding unnecessary costs and expensive, preventable complications for patients in nursing homes through the Nursing Home Quality Initiative (NHQI) and the parallel initiative known as the "Quality First" initiative. Though the NHQI, the Quality First Initiative, CMS has published public reporting of nursing home and home health quality measures. These initiatives have been very successful in measurably improving the quality of care in the nation's 18,000 nursing homes in every state and territory. For example, data from NHQI indicates that the long-term care prevalence of pain has improved every quarter over the last two years in 100 percent of states. On average, the prevalence of pain in long-term care patients has declined 38 percent over the last two years.

Another measure of quality in nursing homes is the daily use of physical restraints, which has declined in 92 percent of states. On average, the daily use of physical restraints has declined by 23 percent over the last two years. Another measure, the short stay (post-acute) prevalence of pain has improved in 96 percent of states. On average, the prevalence of pain in short stay residents has declined by 11 percent.

Quality improved even more dramatically in those nursing homes around the country that partnered more intensively with their state quality improvement organizations (QIOs). We strongly encourage nursing homes who wish to join in this effort to contact their state QIO to learn more about quality improvement programs and to obtain resources to help in their quality improvement efforts.

Although our initial efforts have yielded great results, we still have a long way to go. Some quality measures are proving more challenging to improve. For example, the pressure ulcer measure has remained essentially unchanged nationally over the last two years, although a few states now seem to be making some progress on this measure.

And it is important to remember that quality improvement is not a static process—for example, we are constantly working to enhance our measures and broaden from clinical to patient experience of care and systems of care measures. Our goal should be to create an environment of continuous quality improvement, of sharing and cooperation among the QIOs, State Survey Agencies, nursing homes and professional organizations, and even our beneficiaries and their families together we create an "environment of quality."

In order to achieve this goal, CMS believes that we will have to keep re-examining the way we accomplish our work, and even to re-invent the nature of the public-private partnership. The "Quality First" initiative and the National Commission for Quality Long-Term Care are examples of reinvigorated new partnerships that can propel the quality agenda forward at an ever-increasing pace. To make the participation of our partners easier, in December we created the CMS Long-Term Care Task Force of the Quality Council. The Long-Term Care Task Force (LTCTF) was created to coordinate the long-term care (LTC) program within CMS and to serve as an internal advisory panel for the Administrator.

Helping Beneficiaries Make Informed Choices

Through NHQI, CMS has expanded its efforts to inform consumers about the care available in the nation's nursing homes through the Nursing Home Compare Web site at www.medicare.gov. Nursing Home Compare web allows consumers to search by state, county, city, zip code, or by facility name for information on any of the 18,000 Medicare- and Medicaid-certified nursing homes. The web site includes data on the facility's care record for regular and complaint surveys, staffing levels, number and types of residents, facility ownership, and quality measure scores in comparison to state and national averages. Over the last two years the number of clinical topics covered by the publicly reported quality measures has increased from eight to fifteen. Nursing Home Compare is one of the most popular sites on www.medicare.gov, receiving an average of 13 million page views in 2004.

Conclusion

Mr. Chairman, Medicaid's current system of covering long-term care is outdated, yet it remains one of largest sources of funding for long-term care for the elderly and persons with disabilities. We are at a crossroads. Today, most Medicaid funds for long-term care goes to institutional services that are relatively costly on a per-person basis and even though beneficiary-controlled services can clearly lead to substantial improvements in the quality of life of beneficiaries, and even though many elders and people with disabilities who are now in institutional care have expressed their clear preference and desire is to remain in their own home. To improve quality in Medicaid, to help Medicaid dollars go further, and most importantly to give people with a disability control of their long-term care services, we need to address the institutional bias in Medicaid. We look forward to working with you to strengthen Medicaid and enable the program to provide better support for the millions of Americans who count on it.

We know that community-based services are not for everyone and for this reason we will continue to ensure quality services are offered in institutional settings. However, today we have the opportunity to continue the work the President has begun and forward the cause of community living for those who prefer it to institutional care. If we believe that every American—young and old—has the right to live in the community, if we have really learned that this can be achieved, the time is now to go farther down the “road to independence.” It is time for action by Congress to give individuals the choice and control over their future that they deserve.

If Congress were to create the Medicaid program in 2005, extensive regulatory hurdles to get a waiver would almost certainly be required for a state to provide an institution-only benefit. When we know how to make Medicaid better, when we know we can get better results and serve more people without spending more money, it is time to change the law along the lines of the proposals in the President's FY 2006 budget.

Thank you, Mr. Chairman, for the opportunity to speak to you today about the impact of long-term care on Medicaid costs and the need to eliminate the institutional bias in the Medicaid program. I look forward to working with you as we move forward with Medicaid reform. I would be happy to answer any questions you may have.

Mr. DEAL. Thank you, Dr. McClellan, and Dr. Holtz-Eakin, the Director of the Congressional Budget Office. We are pleased to recognize you for an opening statement for 5 minutes.

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. HOLTZ-EAKIN. Thank you, Mr. Chairman, Congressman Brown, members of the committee.

The CBO is pleased to have the chance to appear here today. We wrote a report on this topic last year, and have submitted a written testimony for the record. I will make only a few brief points, most of which have already been touched upon and expressed probably more eloquently by members in their opening statements.

Point one is that with the demographic change in the United States, and the aging of the baby boom generation, it is quite likely that we will face a rising demand for long-term care services, and along with that will be a rising demand in resources to fund these long-term care services from what are already substantial levels.

We estimate about \$200 billion in 2004 including the value of donated care, this is about \$25,000 per senior with impairments.

Distributing the burden of those costs is a key aspect of both policy design and the long-term budget outlook, and at the moment, current financing is heavily influenced by rules that do not provide incentives for individuals to make their own financial preparations, and if left unchanged, those incentives will add to the financial demands on programs in the Federal budget at a time when there will be increasing budgetary stress.

So let me walk you through some of the nuts and bolts underneath that. First, the costs, if we could go to the first slide. The demography, I think, is now familiar to members of the committee. We anticipate that in the baseline, the rising share of the population that is either 65 and older at the top, or 85 and older, the high demanders of long-term care services, the bottom line, that rising share of the population in those age groups will cause the fraction of our national dollar devoted to long-term care to rise from 2 percent now to 2.3 percent, a rise of about 15 percent, and that is driven by the tripling in the share of the population that is 85 years of age or older.

As with most of these long-term projections in the healthcare area, this one comes with some uncertainty. A key piece of uncertainty here is the rate at which impairment will be present in this population. This projection assumes that impairment continues to decline at the pace we have seen, about 6 percent per decade. If that were not to be the case, the costs would grow even more rapidly. They would rise by about 65 percent, something that looks closer to the rise in Social Security outlays.

Step two is to ask how will these costs be financed, and at the moment, go to the second slide, we have a distribution of these costs in a variety of forms. The dominant form of these costs is donated care. Informal care by family members has been mentioned by many members of the committee. This is the largest form of care. It is very difficult to value. Estimates range from \$50 to \$200 billion. But even for seniors with severe impairments, it is the majority of time the case that this is their only source of care, so it is an important part of both the provision and financing. And the demography may work against this in the future. Families are expected to be smaller. Patterns of marriage and divorce have made it less likely that caregivers may be in the home, and so on both fronts, the demography is affecting this piece of the financing.

The second biggest chunk is out-of-pocket self-insurance, and there, the key issue will be how many Americans will have adequate financial resources to take that as their means of meeting the financing burden. A very small private source at the moment is private long-term care insurance, as has been mentioned in some of the opening statements. This is currently about \$750 out of the \$25,000 per senior, and one of the striking features at the moment is the small take-up in private long-term care insurance, about 10 percent of folks taking that up. And then, the dominant public programs, Medicare at \$4,000 out of the \$25,000, and Medicaid, at about \$5,500, of which 56 percent is the Federal Government's share.

So what issues does this present the committee and the Congress going forward? Well, first it is important to remember that this will take place in the context of larger budgetary demands. In a report that the CBO did in 2003, we documented the long-term budget outlook in the health area. If things go better than they have for the past three decades, it will be the case that Medicare and Medicaid will triple in size. They will rise from 4 percent of our national income to 12 percent. It is in the context of a great many demands on the Federal budget that this problem should be addressed.

That suggests that one should use dollars wisely, that one should balance both within programs, between institutionalized care and home-based care for Medicaid, balance between programs, who will carry it, between Medicaid and Medicare, and it may be the case that it will provide incentives to limit the size of the Federal programs, for example, by limiting middle income families' eligibility, through spend-down rules or other changes.

It may also be desirable to encourage either greater self-insurance, personal saving to cover out-of-pocket costs for the private long-term care market. There, there has been some research that has tried to understand the relatively low take-up of private long-term care insurance, and has focused on the degree to which factors such as administrative costs can explain that, whether it is premium instability or the difficulty of insuring the services when the prices are quite hard to forecast. There has been some focus on whether it is just adverse selection, only those folks who really know they are going to use this insurance buy it, or the degree to which the presence of alternative sources of insurance, the public programs, Medicaid, or the perceived long-term care benefits in Medicare, are the source of crowding out the private long-term care insurance market.

All these are important issues. They will determine the mix of financing for what appears to be a rising demand for long-term care services in the future, and I thank the committee for the chance to be here today, and look forward to answering your questions.

[The prepared statement of Douglas Holtz-Eakin follows:]

PREPARED STATEMENT OF DOUGLAS HOLTZ-EAKIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to be here today to discuss the cost and financing of long-term care (LTC) services. A Congressional Budget Office (CBO) report from April 2004, Financing Long-Term Care for the Elderly, examines these issues in greater detail. Long-term care is the personal assistance that enables people with impairments to perform daily routines such as eating, bathing, and dressing. Such services may be provided at home by family members and friends; through home and community-based services such as home health care, personal care, and adult day care; or in institutional settings such as nursing or residential care facilities.

In my statement today I want to make the following points:

- With the aging of the baby-boom generation, the United States' elderly population is expected to grow rapidly over the next several decades. The surge in the number of seniors will increase the number of people with impairments and, in turn, the demand for long-term care services.
- The resources devoted to long-term care services are already substantial. CBO estimates that spending on such care for the elderly (including the value of donated care) totaled over \$200 billion in 2004—or approximately \$24,000 per senior with impairments. In reporting estimates of LTC spending, CBO chose to

- include the value of donated care because it is an integral part of long-term care, even though measuring it accurately is difficult.
- Currently, donated care is the largest source of financing for long-term care costs, followed by the combined public programs—Medicaid and Medicare—and out-of-pocket expenditures. Private long-term care insurance is a small portion of the current financing.
 - Financing patterns for long-term care are heavily influenced by the rules governing public LTC programs. Those rules create incentives that discourage people from making their own financial preparations and encourage them to rely on government assistance. If left unchanged, those incentives will add to the financial demands that government programs for retirees are already facing as a result of demographic changes and rising health care costs.

DEMOGRAPHIC TRENDS

The oldest members of the baby-boom generation become eligible for early retirement under Social Security in 2008. According to estimates by the Bureau of the Census, the number of elderly people (those age 65 and older) in the United States will increase by two and a half times between 2000 and 2050. The share of the population claimed by the oldest seniors, those age 85 and older—and those most likely to use long-term care—will reach about 5 percent by 2050, more than triple the 1.5 percent share they had in 2000 (see Figure 1). By comparison, the proportion of the population accounted for by working-age people (ages 20 to 64) will grow by only about 35 percent by 2050.

Although the number of the oldest seniors will rise, declines in the prevalence of functional impairment could offset some of the effects of that increase. Impairment among seniors appears to have waned significantly during the 20th century. From 1910 to the early 1990s, the overall prevalence fell by about 6 percent per decade. From the early 1980s to the present, the prevalence of impairment may have fallen even faster, according to research findings from the *National Long-Term Care Survey*. In contrast, some types of impairment, such as those requiring the use of a cane to walk, have been increasing. Impairment among people under age 65 may also be increasing, which could eventually lead to higher future rates of impairment among seniors. In fact, one recent study projects that the currently declining trend in the prevalence of impairment among seniors will reverse in the future, leading to greater rates of institutionalization than those that exist today.¹ As those conflicting trends suggest, projecting the prevalence of impairment in future years and basing estimates of spending on those projections are both difficult and subject to a high degree of uncertainty.

Demographic changes may affect the composition of LTC financing in the future as well. Smaller families, lower fertility rates, and increasing divorce rates may make donated LTC services less common in the future. The size of the average family has declined, reducing the number of adult children available to care for their elderly parents. Family size fell from 3.8 members in 1940 to 3.1 members in 2000; if current trends continue, it will decline to 2.8 people by 2040. At the same time, the rate at which women participate in the labor force will probably continue to grow, at least until 2010, further reducing the availability of donated care. Those family-related trends, in sum, could further stimulate the demand for formal, or paid, services.

SOURCES OF LONG-TERM CARE FINANCING

Long-term care is financed with both private resources and public programs (see Figure 2). Private resources include donated care, out-of-pocket spending, and private insurance. Public programs include primarily Medicaid and Medicare, although the Department of Veterans Affairs and the Social Services Block Grant program also fund long-term care.

Private Sources

Most seniors with impairments who reside in the community, including those with severe impairments (unable to perform at least four activities of daily living, or ADLs), rely largely on donated care from friends and family. And many people who pay for care in their home also rely on some donated services.

The economic value of donated care is significant, although estimates of it are highly uncertain. In 1998, the Department of Health and Human Services estimated that replacing donated LTC services for seniors with professional care would cost

¹Darius Lakdawalla and others, "Forecasting the Nursing Home Population," *Medical Care*, vol. 41, no. 1 (2003), pp. 8-20.

between \$50 billion and \$103 billion (in 2004 dollars). Another analysis, in 1997, estimated the value of donated care for people of all ages who had impairments—measuring it as the forgone wages of caregivers—at \$218 billion.²

Out-of-pocket spending in 2004 accounted for about one-fifth of total LTC expenditures, or roughly \$5,000 per senior with impairments (see Table 1). The federal government subsidizes a portion of out-of-pocket spending through the tax code. Taxpayers with impairments (or taxpayers who have dependents with impairments) may deduct LTC expenses from taxable income along with other medical and dental costs, but only the portion of total medical costs (LTC, medical, and dental expenses) that exceeds 7.5 percent of adjusted gross income.

Private insurance for long-term care is a relatively recent development and pays for only a small amount of care at present. Few elderly people currently have private coverage—no more than 10 percent.³ However, that source of financing is growing—although the precise extent of the growth is difficult to measure accurately. The data on private LTC insurance generally capture payments that insurers make directly to providers but do not always pick up insurers' reimbursements to policyholders for covered services that policyholders initially pay for out of pocket. Thus, estimates of LTC insurance payments—and of out-of-pocket spending—should be interpreted with caution because the former may be underestimated and the latter overestimated.

In 1995, private insurance paid about \$700 million for LTC services for seniors, or 0.8 percent of all such expenditures. In 2004, such spending totaled about \$6 billion, CBO estimates, or about 3 percent of total expenditures. According to America's Health Insurance Plans, the number of policies written yearly increased from about 300,000 in 1988 to more than 900,000 in 2002 (see Figure 3). About 9.2 million policies were sold from 1987 through 2002; roughly 72 percent of them are still in force.

A typical LTC insurance policy pays the cost of nursing home care and home and community-based care but specifies a maximum daily benefit (such as \$100 or \$150) and may impose other limits. Policies with so-called inflation protection increase the dollar value of their benefits by a contractually specified percentage each year, usually 5 percent. Although some policies offer coverage for an unlimited period, most commonly cover services for a shorter time, such as four years, or until benefit payments for a policyholder reach a preestablished maximum lifetime amount. Policyholders typically become eligible to collect benefits when they reach a specific minimum level of impairment, usually defined as being unable to perform two or three ADLs or having a cognitive impairment significant enough to warrant substantial supervision.

Premiums for LTC insurance reflect the cost of services and the risk that policyholders will require long-term care as they age. In 2002, the average annual premium for a typical policy with no inflation protection or nonforfeiture benefit was \$1,337 if the policy was purchased at age 65; with those two added features, the premium rose to \$2,862. Premiums were three to four times higher if the policy was purchased at age 79 (see Table 2). The lower premiums offered to younger people reflect the lower risk of their requiring LTC services at younger ages and the expectation that younger policyholders will pay premiums over a longer period than will people who purchase coverage when they are older. Thus, the average annual premium for the same policy with inflation protection and a nonforfeiture benefit purchased by a 40-year-old would be only \$1,117 and by a 50-year-old, \$1,474.

In fact, fixed premiums are a key feature of LTC insurance policies—that is, the premiums do not increase as the policyholder grows older or as his or her health deteriorates, even though the risk of requiring services rises. Instead, insurers calculate premiums to ensure that the premiums' total, paid over the life of a policy, plus the interest that accrues from investing them will be sufficient to cover both the claims of the policyholder and insurers' profits and overhead costs. However, insurers reserve the right to increase premiums for a specific group, or rating class, of policyholders—such as all policyholders in a state—if new data indicate that expected claims will exceed the class's accumulated premiums and their associated investment returns.

² Peter S. Arno, Carol Levine, and Margaret M. Memmott, "The Economic Value of Informal Caregiving," *Health Affairs*, vol. 18, no. 2 (1999), pp. 182-188. CBO converted their estimate of \$196 billion in 1997 dollars to \$218 billion in 2004 dollars.

³ Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

Government Programs

Medicaid is the biggest government source of payment for long-term care. Jointly funded by the federal and state governments, Medicaid is a means-tested program that pays for medical care for certain groups of people, including seniors with impairments who have low income or whose medical and long-term care expenses are high enough that they allow those seniors to meet Medicaid's criteria for financial eligibility. Within broad federal guidelines, the states establish eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment; and administer their own programs. The share of each state's Medicaid expenditures that is paid by the federal government is determined by a statutory formula; nationwide, the federal share of the long-term care portion of Medicaid spending is about 56 percent.

Medicaid generally pays for services provided both in nursing facilities and in the home, although the specific benefits that the program provides differ from state to state, as do patterns of practice, the needs and preferences of beneficiaries, and the prices of services. In total, Medicaid's expenditures for long-term care for elderly people since 1992 have grown at an average annual rate of about 5 percent (see Figure 4). CBO estimates that in 2004, Medicaid's payments for institutional care for seniors, including both state and federal expenditures, totaled about \$36.5 billion. Accounting for about 40 percent of total expenditures on nursing facilities, Medicaid's payments cover the care of more than half of all elderly nursing home residents.⁴

Medicaid's expenditures for home and community-based services (HCBS), which include home health care, personal care services, and spending under HCBS waiver programs, are much smaller than its spending for nursing homes—HCBS expenditures constitute only about 23 percent of total Medicaid LTC spending. (Under the waiver programs, states have the option of providing people with impairments with enhanced community support services not otherwise authorized by the federal statutes.) Since 1992, Medicaid spending for home-based care for seniors has grown faster than spending for institutional care, rising by about 11 percent annually, on average, compared with about 3 percent growth for care in nursing facilities.

Many people who are not eligible for Medicaid while they live in the community become so immediately or shortly after being admitted to a nursing facility because of the high cost of institutional care. (Nursing home costs in 2004 averaged about \$70,000 annually for a private room.) According to a 1996 study, about one-third of discharged nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances; nearly one-half of current residents had similarly qualified for coverage.⁵ Medicaid coverage is especially common among nursing home patients who have been institutionalized for long periods.

Medicare, the nation's health insurance program for the elderly, covers care provided in skilled nursing facilities (SNFs) and at home, but its benefits are designed primarily to help beneficiaries recover from acute episodes of illness rather than to provide care for long-term impairment.⁶ Medicare covers up to 100 days per spell of illness for SNF care, and the stay must be preceded by a hospitalization lasting at least three days. In contrast, Medicare's home health benefit, while originally conceived to finance short-term rehabilitation, has evolved into what some observers have described as a de facto LTC benefit. To be eligible for reimbursement under the home health benefit, the beneficiary must be homebound and require intermittent care provided by a licensed professional, such as a registered nurse or physical therapist. If those conditions are met, Medicare will cover services provided by a

⁴ See Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey*, Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000). The disparity between Medicaid's share of total spending on nursing facilities (40 percent) and the proportion of patients covered by Medicaid (56 percent) may result from one or more factors: Medicaid's low average reimbursement rates; differences between the severity of Medicaid enrollees' conditions and the conditions of patients using other sources of payment; and enrollees' cost sharing, which counts as out-of-pocket spending.

⁵ Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996). Those proportions differ because discharged residents include people who were institutionalized for only a short time, and the sample of current residents includes more people who stay for extended periods.

⁶ Medicaid's nursing facility benefit (institutional care), in addition to covering skilled care provided in a SNF, also covers nonskilled care that may be provided in a SNF or nursing home. Medicare's SNF benefit, however, covers only skilled care provided in skilled nursing facilities.

home health aide, in addition to skilled care; aide services are the assistive services that typify long-term care.

By CBO's estimate, Medicare's LTC spending for seniors in 2004 totaled about \$16 billion for care in skilled nursing facilities and \$18 billion for home health care (see Figure 5). Although the program's outlays for those categories grew rapidly from the late 1980s to the mid-1990s, expenditures actually declined near the end of the past decade. A combination of factors was responsible, including changes to reimbursement methods imposed by the Balanced Budget Act of 1997, increased federal activities to counter providers' fraud and abuse of the program's payment systems, and delays in processing claims. CBO projects steady growth in spending for SNF and home health care over the 2006-2015 period, averaging approximately 5 percent annually.

ISSUES IN CONTROLLING FEDERAL LONG-TERM CARE SPENDING

CBO has projected that total LTC expenditures for seniors (including the value of donated care) will rise from about \$195 billion in 2000 (2.0 percent of gross domestic product, or GDP) to \$540 billion (in 2000 dollars) by 2040, or 2.3 percent of GDP.⁷ That estimate of a relatively modest increase in use of long-term care services incorporated the assumption that the prevalence of impairment would decline at a rate of about 1.1 percent per year. If impairment levels instead remain about the same as they are today, use of services will rise faster, to \$760 billion by 2040, or about 3.3 percent of GDP. Demand for care could be even higher if, as some researchers believe, the prevalence of impairment actually increases in the future.

The current mix of financing for long-term care, in which a significant share of financing comes from government programs, adds to the pressures that the federal budget will experience with the aging of the baby-boom generation. Contributing to the strains that government LTC programs will face are incentives created by those programs that diminish the attractiveness of using private resources—especially private insurance—as a means for seniors to finance their care. Changes in those incentives might encourage more people to make their own preparations for financing their care rather than rely on governmental assistance.

Direct Approaches to Limiting Federal Spending for Long-Term Care

One approach to relieving the pressures on federal finances would be to directly reduce the role of Medicaid and Medicare, the programs responsible for the bulk of government-financed care. The most commonly discussed options are tightening the financial qualifications for people applying for Medicaid coverage and reducing Medicare's coverage of home health care.

Medicaid's spending for long-term care could be constrained by making it more difficult for middle-income people to qualify for coverage by spending down their resources. The intent of Medicaid's current rules is to restrict applicants to those who are destitute. Yet despite that intention, many applicants manage to protect a significant portion of their personal wealth and still qualify for Medicaid coverage by taking advantage of certain rules regarding the disposition of assets, a practice known as Medicaid estate planning. Strengthening the rules to reduce the use of such strategies would delay the point at which some people became eligible for benefits and would prevent others from qualifying. It could also discourage some people from going through the application process. However, it is unlikely that imposing those additional restrictions would have more than a modest impact on Medicaid's expenditures.⁸

Medicare's home health care benefit is relatively generous. Once a person meets the physical qualifications for coverage, there are no copayments or other coinsurance requirements. A modest cost-sharing requirement for beneficiaries could decrease the program's LTC expenditures because beneficiaries would probably reduce the amount of care they used in response to that kind of financial incentive.

Challenges in Encouraging Private Financing of Long-Term Care

Future federal spending on long-term care could be lessened by encouraging people to rely more on private resources for their LTC needs. Out-of-pocket spending and donated care already account for a very substantial share of LTC services, but private long-term care insurance currently finances very little such care. CBO estimates that the proportion of LTC spending that private insurance pays will rise to

⁷Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly* (March 1999).

⁸Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006* (March 2005). CBO estimated that the President's proposal to change the penalty period for illegal asset transfers would save \$3 billion over 10 years.

about 17 percent in 2020; that share would be less than the shares of either Medicaid or Medicare. Several factors underlie the limited rise that CBO projects for the use of private insurance. Some factors affect the availability and quality of insurance: they include issues related to administrative costs, the instability of premiums, adverse selection, and the inability to insure against certain risks unique to long-term care. A final factor—the interaction of private insurance and Medicaid—is critical in the way it affects demand for private insurance.

Administrative Costs. Administrative costs contribute a substantial amount to LTC insurance premiums because most policies are sold individually rather than as group (employer-sponsored) policies.⁹ The costs of marketing to and enrolling individuals are about double those for groups, for which fixed administrative costs may be spread over more people.

On average, administrative costs as a percentage of premiums are likely to fall in the future as group policies make up a larger share of the private LTC insurance market. In 2002, group policies constituted nearly one-third of new LTC policy sales.¹⁰ (By comparison, nearly 90 percent of people with private health care insurance hold group coverage.¹¹) But group policies are accounting for an increasing share of the LTC insurance market, a trend that is likely to continue if more employers offer LTC coverage as an employee benefit. If employers offer such a benefit, any part of the premiums for their employees' LTC coverage that they pay for, like their contributions for regular health insurance, is not included in employees' taxable income.

Instability of Premiums. Although LTC insurers typically offer premiums that do not automatically increase as the policyholder grows older or experiences deteriorating health, state insurance regulators allow insurers to increase premiums for all holders of a given type of policy in a state (known as a rating class) if they find that they have miscalculated the expected cost of their claims. Some insurers have boosted premiums several times for that reason, leading many policyholders to cancel their coverage and in all likelihood deterring some potential purchasers from acquiring LTC coverage.¹² However, premiums may be stabilizing: a survey of top-selling LTC insurance carriers by the Health Insurance Association of America observed fairly steady premium levels from 1997 to 2001 after a sustained decline in average premiums from 1990 to 1996.¹³

Policyholders can obtain some protection against large jumps in premiums by purchasing nonforfeiture benefits with their policy. That feature enables policyholders who cancel their coverage to recoup from the insurer at least some of the premiums they have paid. Nevertheless, although policyholders might get a proportion of their premiums back, they do not receive the associated returns on the investment of that money.

Adverse Selection. The relative newness of the market for LTC insurance and the still fairly small number of policies being sold suggest that the market may be affected by adverse selection. People who purchase LTC insurance have greater expectations than nonpurchasers of using services in the future, and those greater expectations are not captured in the information that insurers collect as they enroll purchasers of their policies. If insurers believed that adverse selection was occurring, it might lead them to set premiums higher than a policyholder's health status would suggest so as to incorporate the greater likelihood that that policyholder would use the insurance. In turn, the higher premiums might deter people who would purchase coverage if the premiums reflected their relatively lower expectations of using LTC services.

One recent study suggests, however, that although adverse selection does exist in the LTC insurance market, it may not be producing higher overall claims costs.¹⁴ According to that study, the higher costs of policyholders with greater-than-average expectations of using services in the future are offset by the lower costs of policyholders who are averse to risk and whose probability of using services in the future

⁹ America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 11.

¹⁰ America's Health Insurance Plans, *Long-Term Care Insurance in 2002*.

¹¹ Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, Current Population Reports, Series P60-226 (Bureau of the Census, August 2004).

¹² Ann Davis, "Shaky Policy: Unexpected Rate Rises Jolt Elders Insured for Long-Term Care," *Wall Street Journal*, June 22, 2000, p. A1.

¹³ Susan A. Coronel, *Long-Term Care Insurance in 2000-2001* (Washington, D.C.: Health Insurance Association of America, January 2003).

¹⁴ Amy Finkelstein and Kathleen McGarry, *Private Information and its Effect on Market Equilibrium*, Working Paper No. 9957 (Cambridge, Mass.: National Bureau of Economic Research, September 2003).

is actually lower than the average for the population at large. Because of the market's youth, there are no clear data to resolve the question of adverse selection.

The Inability to Insure Against Certain Risks. Private LTC insurance may be unattractive to some consumers because it does not, in general, insure against the risk of significant price increases for long-term care. Most policies promise to provide contractually specified cash benefits in the event that a policyholder becomes impaired. To protect themselves against LTC price inflation, consumers can purchase a rider to their policy under which the policy's benefits grow at a specified rate each year (usually 5 percent); however, such riders offer no protection against additional costs if prices rise at a faster pace. Concerns about price increases of that kind are not unjustified: Medicaid's average reimbursement rates for nursing facilities grew at an average annual rate of 6.7 percent from 1979 to 2001.¹⁵ Over a 20-year period, a nursing facility benefit of \$100 per day in today's dollars would grow to \$265 per day with an annual inflation protection rider of 5 percent. But the benefit would need to grow to \$366 per day to keep up with a 6.7 percent annual growth rate, should costs continue to grow that fast in the future.

An additional risk is that a policy could become obsolete at some point in the future. LTC services, and the private insurance policies that cover such care, are steadily evolving as the LTC insurance market matures. That fluidity may give some consumers pause, and indeed, one prominent rating agency recommended in 2000 that people purchase LTC coverage no earlier than age 60 to avoid the problem of obsolescent coverage.¹⁶ Some consumers might also be reluctant to purchase LTC insurance if they believed that changes in public policy at some point could render their coverage obsolete.

The Availability of Medicaid. The availability of Medicaid poses a substantial disincentive for people considering the purchase of private long-term care insurance. Although Medicaid in general serves people with very low income and assets, it also provides assistance to people with impairments who exhaust all of their private sources of financing for their long-term care. Even people who have set aside significant savings may eventually become eligible for Medicaid assistance. In that way, Medicaid serves as an alternative form of insurance for people who do not have private coverage and who are impaired for a significant period. Indeed, Medicaid's impoverishment requirement may discourage people from saving because the less they have, the more quickly they will qualify for coverage. It also creates an incentive for people to give away or hide their assets so that they can qualify for Medicaid.

There are substantial drawbacks to Medicaid coverage for long-term care. As a means-tested program, Medicaid requires eligible applicants to rely on out-of-pocket spending until they use up all of their savings. In addition, because Medicaid generally pays lower fees for services than those paid by private payers, beneficiaries may not receive the same quality of care that private policyholders receive. In some states, moreover, Medicaid might not be as flexible in the types of services it covers as private insurance would be; a person who has private coverage would probably have a broader choice of providers and types of care than a Medicaid beneficiary would have.

Those drawbacks to Medicaid's coverage are balanced by features that some people might consider advantageous. Medicaid is free from the perspective of the beneficiary. In addition, Medicaid has a defined-benefit structure—that is, it covers a specified set of services. Private insurance, by contrast, only ensures that a policyholder will have a specified monetary benefit to pay for care. It does not guarantee that the money will be sufficient to pay for desired services.

Although Medicaid's coverage differs in some respects from that of private insurance, it may nevertheless reduce the demand for private policies. Indeed, one recent study found that the availability of Medicaid constitutes a substantial deterrent to the purchase of private insurance, even for people at relatively high income levels.¹⁷ Medicaid's rules for financial eligibility affect people's decisions to purchase private LTC insurance as well as how much insurance they buy because the rules offer a low-cost alternative (by allowing people to qualify for the program's benefits) to making personal financial preparations for possible future impairment. People who buy private insurance or accumulate savings substantially reduce the probability that they will ever qualify for Medicaid's benefits, thereby forgoing the value of the government-provided benefits that they might otherwise have obtained. Thus, the

¹⁵ Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004), p. 19.

¹⁶ See Weiss Ratings, Inc., *Long-Term Care Policies Vary Drastically in Cost to Consumers* (Palm Beach Gardens, Fla.: Weiss Ratings, Inc., April 5, 2000). Weiss Ratings evaluates the financial condition of insurers (including companies that sell life, health, property and casualty, and LTC insurance) as well as banks and savings and loan institutions.

¹⁷ Brown and Finkelstein, *The Interaction of Public and Private Insurance*.

availability of Medicaid raises the perceived cost of purchasing private insurance or of saving. That increase is small for relatively wealthy people who have little likelihood of ever qualifying for Medicaid coverage, but it can be substantial for others.

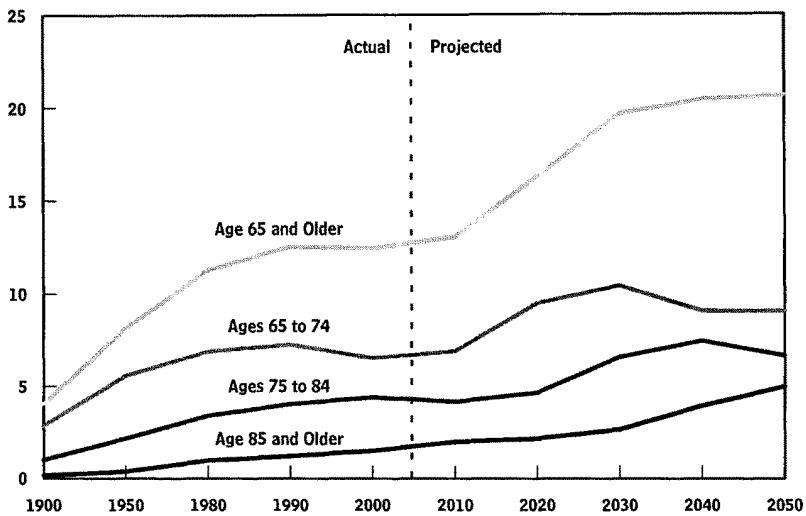
CONCLUSION

Currently, elderly people finance LTC services from various sources, including both private resources and government programs. Incentives inherent in the current financing structure have led to increased reliance on and spending by government programs and may have discouraged people from relying on private resources (savings, private LTC insurance, and donated care) to prepare for potential future impairment. The demographic changes projected for the coming decades will bring increased demand for long-term care and heightened budgetary strains.

Figure 1.

People Age 65 and Older as a Share of the U.S. Population, Selected Years from 1900 to 2050

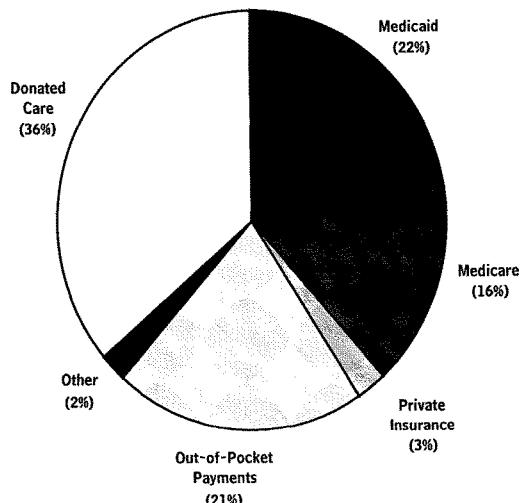
(Percent)



Source: Congressional Budget Office based on Bureau of the Census, *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*, Table 2a, "Projected Population of the United States, by Age and Sex: 2000 to 2050" (March 2004), available at www.census.gov/ipc/www/usinterimproj/natprojtab02a.pdf.

Figure 2.

Estimated Percentage Shares of Spending on Long-Term Care for the Elderly, 2004

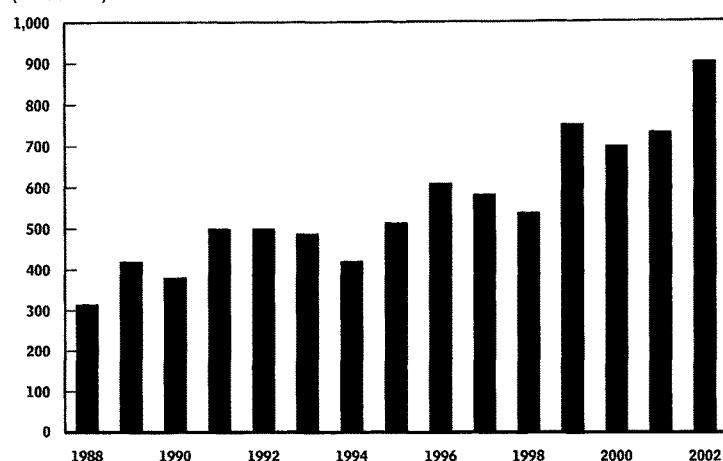


Source: Congressional Budget Office.

Figure 3.

Annual Number of Policies of Private Long-Term Care Insurance Sold, 1988 to 2002

(Thousands)

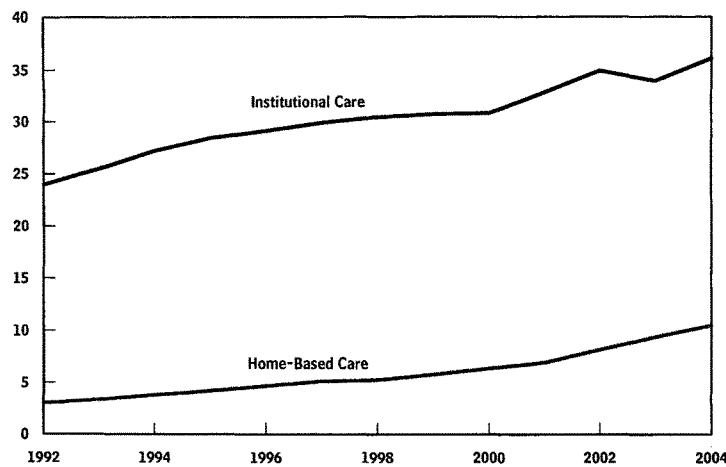


Source: America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 15.

Figure 4.

Medicaid Long-Term Care Expenditures for Elderly Beneficiaries, Fiscal Years 1992 to 2004

(Billions of dollars)

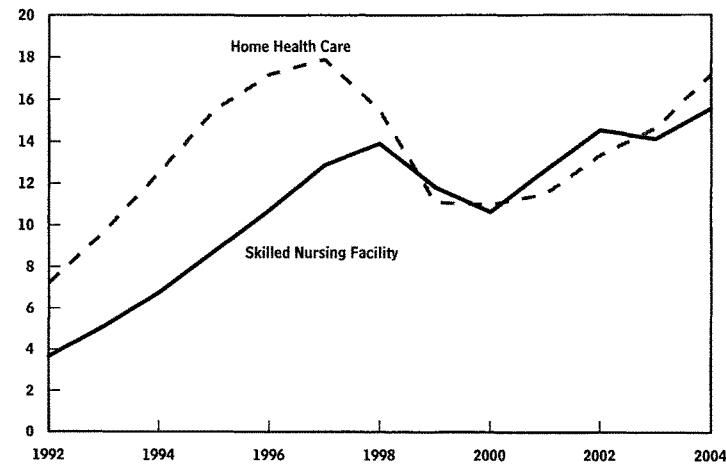


Sources: Personal communication by Brian Bruen of the Urban Institute, and the Congressional Budget Office's estimates.

Figure 5.

Medicare Spending for Skilled Nursing Facility Care and Home Health Care for Elderly Beneficiaries, Fiscal Years 1992 to 2004

(Billions of dollars)



Source: Congressional Budget Office.

Table 1.
**Long-Term Care Expenditures for the Elderly,
by Source of Payment, 2004**

(Billions of dollars)	Institutional Care	Home-Based Care	Total
Public Programs			
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private Resources			
Donated Care	0	76.5	76.5
Out-of-Pocket Payments	35.7	8.3	44.0
Private Insurance	2.4	3.3	5.6
Other ^a	2.0	2.5	4.4
Total	92.4	119.0	211.4

Source: Congressional Budget Office.

Notes: Donated care is measured as the cost of replacing that care with professional services.

Numbers may not add up to totals because of rounding.

a. Includes local public programs, minor federal spending, charity care, and so forth.

Table 2.
**Average Annual Premiums for Long-Term Care
Insurance, 2002**

(Dollars)	No Inflation Protection or Nonforfeiture Benefit	With 5 Percent Compounded Inflation Protection	With Nonforfeiture Benefit	With Inflation Protection and Nonforfeiture Benefit
If Purchased at Age				
40	422	890	537	1,117
50	564	1,134	715	1,474
65	1,337	2,346	1,646	2,862
79	5,330	7,572	6,479	8,991

Source: America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 32.

Note: These premiums are for policies offering a \$150 daily benefit for four years of coverage and a 90-day elimination period.

Mr. DEAL. I thank you, gentlemen. The Chair will recognize himself to begin the questioning.

We, of course, hear a lot of political rhetoric in the environment of the President's proposed budget and the Congressional Budget Resolution with regard to so-called cuts in Medicaid. Dr. McClellan, would you address that issue? Is it really cuts, or is it simply reducing the rate of growth?

Mr. McCLELLAN. First of all, it is simply reducing the rate of growth. The projected rate of growth in Federal Medicaid spending over the next 10 years is about 7.4 percent per year, and the administration's proposals for savings would take that all the way down to 7.2 percent per year. So it is really only a very small part of overall Medicaid spending, and what the proposals are about is getting more for the dollars that we do spend.

For example, our proposal for reducing the overpayments in our regulated prices for prescription drugs in Medicaid saves money for the States, and enables States that are facing a fixed and tight budget to put more dollars into things that really do make a difference in people's lives. Instead of overpayments for the drugs, there would be more care in Medicaid, more support for education programs, making the dollars go further.

Mr. DEAL. One of the things that I have heard repeatedly as I have talked with various Governors around the country is that they are almost unanimous in their urging us to do something by way of reform. Governor of Virginia, Governor Warner, puts it in terms of we are experiencing a meltdown. In talking with Governor Haley Barbour of Mississippi a couple of weeks ago, he says that he appreciates the largesse of the Federal Government. I think his State maybe has the highest rate of participation in terms of Federal dollars versus State dollars, but he said even with that, he can't afford the program, and that he is bankrupt, in terms of Medicaid expenditures, and is going to have to cut somewhere I think in the neighborhood of \$500 million a year.

So it would seem to me that this is a problem that is fairly common at the State level, in terms of what they are experiencing. Is this, Dr. McClellan, is this the kind of response you are having as well?

Mr. McCLELLAN. Yes, it is, Mr. Chairman. My experience, in talking with Governors, is that the States just don't have any more money to spend on this program, and when they say it is unsustainable, and they uniformly do, what they mean is not that Medicaid reforms won't take place. They are taking place in the States now. But if we don't give them better tools to use to get more for the money in Medicaid, the kinds of reforms you are going to see are reductions in benefits and cuts in payment rates to providers. So even if you have a benefit on the book, people don't actually have access to quality care, and cutbacks in so-called optional programs, like the home and community-based waivers that I think are such an important part of making Medicaid work better for the future, are likely to be made.

So we need to move away from that system. That system is not sustainable, and the question is whether we are going to implement reforms that help the States get more for their money, and serve people with quality care better, or whether, the track we are

on now, of reducing benefits, or cutting services, or cutting access to care, is going to continue.

Mr. DEAL. Well, we have heard comments in the opening statements from members such as Mr. Shadegg, who outlined what has gone on with Arizona. Apparently, they have had a long-term waiver that has been in place for a very long time. I know that, and Mr. Bilirakis alluded to a request that Governor Bush from Florida is making for a rather substantial waiver.

Do you have any idea how many waivers have actually been requested over the last several years, and how many are in place?

Mr. McCLELLAN. I don't have a specific number, Mr. Chairman. We will get that for you. But there have been waivers from virtually every State. Again, the statutory Medicaid benefits were designed in the 1960's, and that is just not the way that either acute health care or long-term care ought to be delivered today. And the States know that, and that is why they come in with these proposals that try to get more for the dollars that they are spending than what the Medicaid statute tells them they need to do, and that is true for the home and community-based waiver in Arizona. Florida has taken similar steps to try to give more control to people with a disability, and the parents of kids with a disability concerning how they get their long-term services. But this is not the way the program is designed, and we need to take steps to make it more automatic when we have clear evidence that there are better ways to spend the money. That ought to be where Medicaid starts. You shouldn't have to go through a lot of hoops to get there.

Mr. DEAL. And would you agree that if we are at a point in time where we can look at the program as a whole, we ought to go ahead and make those changes that give that flexibility. For example, one of the complaints I have heard is, from Governors, is that if you cross the threshold of financial eligibility, you then are entitled to the full range of Medicaid services. They would like the opportunity to tailor those services in a better fashion, but absent a waiver or some consent from the Federal Government, they are not able to do that.

Would you agree, then, that rather than continuing this rather hopscotch quilt type approach of waivers, that we really ought to look at the program as a whole, and make the kind of changes that would not only encompass the changes that the Governors want, to give them the opportunity to serve their citizens, but would perhaps also make this program more workable at the Federal level. Would you agree that is what we ought to do?

Mr. McCLELLAN. We absolutely need to be looking at those steps right now. When it comes to benefit packages for some of these so-called optional populations, we have a lot of experience from the SCHIP program, where there is more ability for States to get people in the mainstream coverage, and modify the packages, and they work. The States have expanded coverage in SCHIP, and again, getting back to the long-term care focus of this hearing, consider the home- and community-based services waivers or Money Follows the Person initiative, or our Independence Plus initiatives; the evidence is very clear that we can get better results, meaning higher beneficiary satisfaction, more people in the community, more peo-

ple served, better results for the dollars that we spend. That needs to be put more centrally into the Medicaid program.

Mr. DEAL. Thank you. The Chair recognizes Mr. Brown.

Mr. BROWN. I thank you, Mr. Chairman. Dr. McClellan, give me a yes or no answer to this, because I have a couple other questions I want—you talked about the overpayment for drugs and the Medicaid, as you were talking about Medicaid costs. Do you go along with outgoing Secretary of HHS Thompson on his recommendation to repeal the prohibition in Medicare, for a moment, the prohibition on Medicare of negotiating drug prices?

Mr. MCCLELLAN. No, when Secretary Thompson was involved in all of those discussions, and people looked at what the independent CMS actuaries, and what the CBO analysts had to say, we went for the approach that was going to get the best costs for up to date access to medications, and that is what we are implementing right now.

The recent letter from my actuary, which we can get you a copy of, reiterated that that kind of negotiating authority would not do anything to get significant savings beyond what we are already getting in lowering drug costs—

Mr. BROWN. Except for what has happened in Canada, what has happened with Cipro, what—I don't want to debate that.

I hear you talk about—that—this Medicaid is not a cut. It is only—it is not a decrease, it is only a cut in the rate of growth. And I have heard that from people who want to cut Medicaid and other government programs that have worked for Americans for the last 10 years. Discounting, of course, that is serving a growing population, and discounting that Medicaid increase per capita is smaller than Medicare, it is smaller than private insurance. In fact, the Medicaid per capita increase is only about half of private insurance increase. But I just wanted to set the record straight there.

Dr. Holtz-Eakin, I would like to ask—you had said in your written testimony Medicaid is free from the perspective of the beneficiary. I want to make sure I understand what you mean by that. Under Federal Medicaid statute and regulations, a beneficiary who resides in a nursing home or other institution is required to apply most of her income toward the cost of care. The purpose of this requirement is to reduce the cost of the individual's care to Federal and State governments, obviously.

Take an elderly woman who lives in a nursing home, combined income from her Social Security, and say, her husband has a defined pension benefit of \$1,500 a month. All of—under current rules, all of the \$1,500 but a sort of a set aside personal needs allowance must be applied to the cost of her nursing home care. The personal needs allowance is for expenses, as we know, not covered by Medicaid, such as laundry, hair care. It must, at a minimum, be \$30 a month. States have the flexibility to make it higher. So if a Medicaid beneficiary, say, lives in a nursing home, with her \$1,500 Social Security and pension payment monthly, with a personal needs allowance of \$50, she is paying \$1,450 toward her care in that nursing home. If she had a spouse living in the community, an additional amount would be protected for the spouse, so that he won't be impoverished. The amount protected depends, in part, on

the amount of income the community—the spouse in the community has otherwise.

My question is, after looking at all of that, given the requirement that much of a Medicaid beneficiary's income, in this case, of this lady, \$1,450 a month, be applied to the cost of the care, cost of care, why would a, you know, a fair-minded government official say that—I understand people saying that for political reasons, that Medicaid is a giveaway, it is welfare, it is a bunch of people that are poor, whatever. But I don't understand why a government official with the stature and reputation of you would say that Medicaid is free from the perspective of the beneficiary.

Mr. HOLTZ-EAKIN. The point of the observation in the paper was simply to, in thinking about alternative insurance policies in the public sector and the private sector, make the point that there was no explicit linkage between a premium payment at the front end, and then, insurance benefit coming out at the back end. Those aren't explicitly linked to Medicaid. The eligibility rules clearly are what they are, and you are very conversant with them, but really, it was about premiums versus payouts in an insurance—

Mr. BROWN. I appreciate that answer. I—that sounds like economist talk, but not—but it also lends itself, it lends itself to demagoguery on the part of people that just ideologically don't much like Medicaid, that this is a free program, when in fact, it is not free to beneficiaries.

Give us, if you would, following up on that, can you estimate the amount of out-of-pocket resources individuals on Medicaid contribute to the cost of their care? Do you have some numbers you could give us on that?

Mr. HOLTZ-EAKIN. We have some rough guesses, on out-of-pocket spending in general for those on Medicaid only. Out-of-pocket as a fraction of total services is about 21 percent, and if you include the value of donated care as out-of-pocket, it is about 57 percent. So it depends on which metric you use, just those in the market, or those that include the donated care.

Mr. BROWN. That being said, can we count on you to never again say that Medicaid is free to beneficiaries?

Mr. HOLTZ-EAKIN. I don't think I am that reliable, but I take your point and will be careful about how we describe it.

Mr. BROWN. So you can't quite make that promise, though.

Mr. HOLTZ-EAKIN. The number of times I have guaranteed something for the rest of life and been able to—

Mr. BROWN. Well, I mean, you probably—

Mr. HOLTZ-EAKIN. I take your point, I am just—

Mr. BROWN. Okay, well, I understand. I mean, you seem like a person that tells the truth, so understanding the truth is that is Medicaid is not free to the beneficiary, you get the point. Okay. Thank you, Mr. Chairman.

Mr. DEAL. The Chair recognizes Mr. Barton.

Chairman BARTON. Well, thank you. And I would love to pass a no demagoguery clause for debate, members of this committee. If I could get unanimous consent on the minority side, I think I can make that stick on the majority side. But somehow, we would have to set the fine high enough, the penalty high enough, so that we

could actually enforce it. So it is a serious debate, and obviously, this is a big, big issue. It is an intergenerational issue.

My first question to you, Dr. McClellan. Given what has happened in the Senate, with Senator Smith's amendment on the Commission, and what happened on the House floor last night with the Motion to Instruct, what is your position or the President's position about continuing to go forward to really try to find some Medicaid reforms this year. If you were me and chairman of this committee that has got jurisdiction, would you recommend that we continue to seek for solutions, or would you recommend that I say to heck with it, and let us look at telecom?

Mr. MCCLELLAN. Mr. Chairman, we really hope you will keep after it, with all due respect to telecom.

We stand by our budget proposals. As I have said before, there are ways to spend the dollars a lot better in Medicaid. Some of that can lead to savings for us and for the States, and some of it can lead to better quality care for more beneficiaries who really need help from Medicaid today. This is an urgent problem. We have a tremendous amount of evidence about good ways to go forward that achieve this goal of making Medicaid more up to date and more sustainable, and helping it serve more people who really need it more effectively, and I sure hope you will keep at it.

Chairman BARTON. Well, I am committed to the process, and I know Chairman Deal is. Ultimately, we have to make sure that we have the votes, and that what we want to do makes sense, from the perspective of the population we are trying to help, which is our Medicaid-eligible population.

On a policy question, if we do reform this year, should harmonization between Medicare and Medicaid be a part of that? Because some of these services can be covered either way. You know, Medicare has its own set of issues, separately, but if we are going to start this process, should we look at the best way to provide the benefit, whether it should be a Medicaid benefit or a Medicare benefit?

Mr. MCCLELLAN. I think that can be part of the whole discussion, and I can tell you that there is a lot of interest in doing that from the States. I just got back from a meeting that we held that was sponsored by the National Governors Association yesterday, and is going on today in Chicago, where we talked about how we can implement the new Medicare law effectively. And while a lot of the attention has appropriately been focused on the drug benefit, one of the things that people haven't paid as much attention to, but should, is the fact that the law is really about providing more co-ordinated care, more continuity of care, and more prevention of complications for Medicare beneficiaries. And there are few Medicare beneficiaries who have more to gain from the new benefit than our dual eligibles, who are often getting very fragmented care. Currently, part of it is dealt with in one part of a State agency, another part is dealt with somewhere else. Some of it is dealt with in Medicare, and it is not put together very well. We are trying really hard to make available health plans and other support that do a better job of coordinating care. I mean, working with the States, bringing up the topics in this committee can be a big help in that process.

Chairman BARTON. I want to ask our Director of the CBO, as we do this, is your agency committed, and I am serious about this, I am not interested in going through this process, and getting CBO scores that bear no reality to what the project is that we are looking at—can you convince or commit to this committee, and I don't know how to define fair, but you and I have had discussions on other programs, where we are diametrically opposed to what the score was, can we set the ground rules so that if we are looking at a particular program, what it costs, and what it is projected to cost, that we can at least agree to how to do the scoring?

Mr. HOLTZ-EAKIN. We can set the ground rules in the way that I hope that they have always been set, which is we will examine the legislative proposals in their completeness. We will look at all the impacts that they may have on the economy, and thus feed back to the budget, and show the impact for spending, or revenues, in the case of the Joint Committee, and in places where you have better information than we have, we welcome it. In places where you have questions about it, or disagree with the analysis, and have insights that you want to share, I welcome that as well.

Chairman BARTON. Is it possible to have a system where your staff and the committee staff, on a bipartisan basis, meet to say here is the program, here is what we are looking at, at least to agree, without committing to how you are—what the specific score is going to be. I am not interested in that. I just want a protocol that we both agree that that does cost, or that would save, so that we, you know, we do—we have done things in the Energy Bill where we were trying to limit spending, and they were scored by CBO as increasing spending. And I am not interested in that kind of a process. I want an interactive dialog with the staffs, and in some cases, maybe principals, members, again, on a bipartisan basis, so that we at least understand what the system is, without being—not trying to commit you to a specific dollar score, just how do we do it, the formula, so to speak?

Mr. HOLTZ-EAKIN. I can commit to what I believe is business as usual, and that would involve all of the elements you mentioned, although I can't guarantee agreement on all the details at the end. I am happy to meet with you, the staff is happy to meet on a bipartisan basis, with staff of the committee on a regular basis. We stand ready to explain and accept the information. I believe that is business as usual.

Chairman BARTON. Yes, I have got one more question to Dr. McClellan. Home care, home-based care or community-based care, lots of problems, lots of restrictions. That should be a part of any reform package that we make it possible for individuals—in your testimony, you are very strong on that, that they give them the choice to—they are not prevented from home-based care or community-based care, and set up the ground rules on how to pay for that.

Mr. MCCLELLAN. That is right. We are past the stage where we should be gathering evidence and talking about these kinds of reforms. If you look in my testimony, look at the testimony of some of the other witnesses here today, and go to www.hcbs.org, where we have worked with other groups to compile a lot of this evidence, what you see is that these programs that increase personal control, that give people support to get care how they prefer it, that address

issues like one time transition costs, you will see that they save money. They are based on the fact that the most cost-effective place to provide care for many people on Medicaid is where they would prefer to receive it. There is no place like home.

Chairman BARTON. Thank you. Thank you, Mr. Chairman.

Mr. DEAL. I thank the chairman. Ms. Capps is recognized for questions.

Ms. CAPPS. Thank you, Mr. Chairman. Mr. Holtz-Eakin came before the Budget Committee earlier this year, that I sit on, and I want to go down a series of questions for you about what the effect of the proposal in placing additional restrictions to asset transfers will mean for eligibility for nursing home care.

In March, CBO re-estimated the President's fiscal year 2006 budget, and you estimated that the President's proposal to tighten the current penalty for asset transfers would reduce Federal Medicaid spending by \$1.4 billion over the next 5 years. And since Federal Medicaid long-term care spending is 56 percent of all Medicaid long-term care spending, the Federal part, this implies a total Federal and State savings of over \$2 billion, \$2.5, \$2.6 billion. These savings represent amounts that the Federal and State governments will not be spending on nursing home care while the penalty, delay in Medicaid coverage, is being applied.

During the penalty period, the nursing home will presumably continue to care for the beneficiary. That is—this is the piece that I am trying to get at, in terms of the budgets of the nursing homes. Any payment for this care, then, will have to come from either the beneficiary, or the beneficiary's family, it would seem to me. And my question, first question is, what is your estimate, assume, about how many beneficiaries will be affected by this tightened penalty? Is there a way to sort of look at how this cost will be translated into community care?

Mr. HOLTZ-EAKIN. I don't have the exact number of beneficiaries, but the estimate was built off information that came, actually, from some of the waiver programs, in particular, Connecticut—

Ms. CAPPS. Right.

Mr. HOLTZ-EAKIN. [continuing] which reported that on the order of 30 percent of their beneficiaries had undertaken some sort of asset transfer, and that struck us as a bit high, since Connecticut is not your average State, a little bit higher income, so we estimated it was something on the order of 20 percent of beneficiaries would be in the mix for those affected by the change in the penalty period.

Ms. CAPPS. Okay. About how much, on average, does your estimate assume that would be transferred?

Mr. HOLTZ-EAKIN. About 1 to 2 months worth of nursing home care. The two key pieces in the estimate are 20 percent of the people involved, and the impact is 1 to 2 months of additional care that would be picked up by the beneficiary or their family, in this case, and not on the Medicaid rolls.

Ms. CAPPS. Well, so then, how long—you have kind of said it, but I want to hear it clearly, how long, on average, would this estimate assume that these individuals would be denied Medicaid coverage due to their transfer?

Mr. HOLTZ-EAKIN. This would change their time on Medicaid by 1 to 2 months, about 1½.

Ms. CAPPS. Okay. I guess I am concerned about that 1 or 2 months. And you—the beneficiaries are those—the actual beneficiary would be the one responsible for the \$2.6 billion in the big picture, but in their own case, those 1 to 2 months worth of care. Is that—

Mr. HOLTZ-EAKIN. It is either the beneficiary and the family, and the—

Ms. CAPPS. Well, some—not all beneficiaries have family. I mean, we can assume, but actually, the burden then is on them.

Mr. HOLTZ-EAKIN. The burden would be on the beneficiary, but remember, the notion is that these are assets that they have in hand at the time, and that by changing the penalty period, we simply are estimating they would draw down their assets, instead of being on the Medicaid program.

Ms. CAPPS. And if they can't pay, then the burden would go to the nursing home, or they would be turned out, or I mean, because it is a temporary—how do you see this playing out?

Mr. HOLTZ-EAKIN. Can I get—if I could get slide numbers—

Ms. CAPPS. And then, while you are doing that, I want to ask you about how much would this cost? What is 1 or 2 months worth of care per individual, average, or for Connecticut, or—

Mr. HOLTZ-EAKIN. A ballpark average for private-pay nursing home care is about \$60,000 to \$70,000 annually. If Medicaid for the nursing home care the Federal cost would be about \$35,000 on average per year.

Ms. CAPPS. For 1 to 2 months of care?

Mr. HOLTZ-EAKIN. Per year, and then—so you would be looking at \$5,000 to \$6,000 for private-pay, or \$3,000 for the Federal share of Medicaid costs.

Ms. CAPPS. Okay.

Mr. HOLTZ-EAKIN. [continuing] for 1 month.

Ms. CAPPS. Okay.

Mr. HOLTZ-EAKIN. If we look at slide 9, I don't know if that is possible.

Ms. CAPPS. I am not in the best place.

Mr. HOLTZ-EAKIN. And I won't take—if I—

Ms. CAPPS. Just tell me what it says.

Mr. HOLTZ-EAKIN. Well, it shows you diagrammatically the strategy typically used in sheltering the assets.

Ms. CAPPS. Okay.

Mr. HOLTZ-EAKIN. And the point is that there are assets there.

Ms. CAPPS. But if they have transferred the assets, do they have them?

Mr. HOLTZ-EAKIN. By changing the penalty period, you change the incentives to transfer the assets, and they presumably would not have done so. At the moment, if they have got the assets, in a strategy known as half-a-loaf, they can give away half, voluntarily incur the penalty, and so with certainty, they have got the assets, and they are just incurring the penalty, and then going on to Medicaid more quickly than they would if you changed the penalty period.

Ms. CAPPS. So if they are not transferring a lot of money, what are their assets?

Mr. HOLTZ-EAKIN. We don't have a particular estimate of the total assets involved, but we—if that is something you would like to go to, we would be happy to work with you. This is an area in which—firm estimates of asset transfers for Medicaid purpose are very difficult to pin down. I mean, we have seen estimates for total transfers from this group that are as high as \$40 billion. What a fraction of that might be induced by Medicaid incentives is hard to say. We have seen an estimate of \$2 billion for the transfers from Medicaid incentives alone. It is an area of great imprecision, and one that is worth more study.

Ms. CAPPS. So you are saying it is worth more study. I mean, if we go from this hearing to legislation, there is a lot more information that we need as to the way this is going to affect individual lives.

Mr. HOLTZ-EAKIN. Well, we would certainly be happy to document the information we have, and to the extent that more information is available, we would be eager to see it.

Mr. DEAL. The gentlelady's time has—

Ms. CAPPS. Thank you.

Mr. DEAL. [continuing] expired. Dr. Norwood is recognized for questions.

Mr. NORWOOD. Thank you, Mr. Chairman. Dr. McClellan, it really is good to see you again, and we are glad you are here. I want to mention this to you for fear I might forget it.

I sent you a letter last week on dental health aid therapists, whatever that is. But I really—it is very interesting to me, and very important to me, and I really would appreciate you instructing staff to get me an answer to that as soon as you can.

Mr. MCCLELLAN. You will get it promptly. Thank you.

Mr. NORWOOD. Thank you, sir. My questions are sort of basic. I am trying to understand how in the world would you reform Medicaid. Some people think the answer is oh, gosh, don't spend less money. That isn't a reform, necessarily, but see if you can answer some basic questions.

How many patients in the country are on Medicaid that are receiving benefits for long-term care? Do we know that for 2004?

Mr. MCCLELLAN. We do. I am not sure I have the total number right now. There are about, at any given time, there are about 1.6 million beneficiaries in nursing homes.

[The following was received for the record:]

We do not have the 2004 data available. The most recent numbers we have right now are for 2002. In 2002, there were about 1.6 million beneficiaries who received care in institutional settings, and about 3.8 million individuals receiving home- and community-based long-term care services.

Mr. NORWOOD. All right. Nursing homes, but it is different for those accumulated in long-term care.

Mr. MCCLELLAN. That is right, but most people in nursing homes are on Medicaid. With the increase in the number of home- and community-based waivers, we have now, we estimate, over a million people getting services through one or another kind of these waivers that I have been talking about, at a much lower cost per

person, I might add. And so, there are several million people altogether.

Mr. NORWOOD. Let us talk about the 1.6, and we will figure out what the larger number is. Do we know how much we are spending on the 1.6 million people on nursing home care? Do we have an annual figure per person?

Mr. McCLELLAN. For the 1.6 million, remember, that is the total, and about three quarters of the individuals are getting financing from Medicaid. In institutions, Medicaid spends, on average, over \$30,000 a year, probably around \$33,000 a year, for institutional care, per person.

Mr. NORWOOD. So it is about 33. Do we know, if we look at all the money the Federal Government spends, pretty good, huh?

Mr. McCLELLAN. Yes.

Mr. NORWOOD. Of all the money the Federal Government spends in 2004 on Medicaid, what percent of that money is for long-term care? Or—well, I want to say long-term care, rather than just nursing home.

Mr. McCLELLAN. It is about a third that goes to—

Mr. NORWOOD. Thirty, I have heard 30 to 40 percent.

Mr. McCLELLAN. Yes. That is right. That is right.

Mr. NORWOOD. That is a large amount, isn't it?

Mr. McCLELLAN. It is, and it is an amount that is growing.

Mr. NORWOOD. Off the subject a wee bit, but this is about reform. This is about dollars in Medicaid. Do you know how much money we spend in Medicaid on illegal aliens a year?

Mr. McCLELLAN. I don't think we have a specific estimate of that. It is not as large as the spending on long-term care. There are—

Mr. NORWOOD. I should hope. That is a third.

Mr. McCLELLAN. Right. There are a lot of steps in place that we try to take to make sure that the Medicaid spending is going to people who are legally intended to be covered under the program. If there is a question—

Mr. NORWOOD. Of course, those people are accepted at the State level, so it is sort of out of your hands to some degree, as to whether they are illegally in the country or not.

Mr. McCLELLAN. But we do work with the States to make sure that they are spending the money appropriately. So, it is the States that are on the frontline for making eligibility determinations, but we do monitor State practices.

Mr. NORWOOD. You do that real well?

Mr. McCLELLAN. Well, we are always trying to do it better.

Mr. NORWOOD. I could get you up a few that aren't doing it real well.

Mr. McCLELLAN. There is no question that the problems that many States, especially border States, are facing, with undocumented immigrants, are putting some strains on—

Mr. NORWOOD. Well, it is not just border States.

Mr. McCLELLAN. [continuing] care and hospital care.

Mr. NORWOOD. My home State of Georgia is not a border State, and there is a problem there. Well, I am—time is running out. I got to move quickly. Let me make the point, first, that Mr. Chairman, I have a long-term healthcare policy. Even I do. It is a great

policy. It pays about \$5,000 a month. I think it costs me somewhere \$3,000, \$3,600 a year. I can't understand why in the world it wouldn't be a better plan to have Medicaid patients have long-term care policies, even if we paid the policy. I mean, it has got to be cheaper for the government, and in my personal opinion, it is highly likely that it would be better care.

Last, I want to—okay. Well, I am going to get CBO in just a second, if I have the time. Maybe you could answer the question to that, Mr. Holtz-Eakin, but you are probably pretty qualified to tell us, this committee, if it is a feasible strategy to move a significant number of long-term care recipients or potential recipients to private insurance, like I am talking about, if we continue to have Medicaid just exactly like it exists today. Is it possible to move to long-term care private insurance?

Mr. HOLTZ-EAKIN. The issue is how many people will have the wherewithal to buy a private insurance policy, and the desire to protect their assets to some extent, and given that, what incentives do they have to purchase a private insurance policy, versus rely on a government—

Mr. NORWOOD. They don't have any other way, or we will pay for it. If they can't afford the policy, we will pay for it.

Mr. Chairman, last, I want to point out for the record that earlier, it was mentioned that Medicaid pays for long-term care. I think it is pretty important for us to realize Medicaid doesn't pay for a thing. The American people pay for Medicaid. The taxpayer pays for Medicaid, and they are insisting on some reforms in this program, particularly in long-term care. I thank you for your indulgence, Mr. Chairman.

Mr. DEAL. Ms. Baldwin is recognized.

Ms. BALDWIN. Thank you, Mr. Chairman. Dr. McClellan, I read that you were recently quoted at White House Conference on Aging as saying that you planned on eliminating the institutional bias in Medicaid by December of this year. And as you know, in most instances, it is more difficult to obtain Medicaid coverage of needed care in the home, and thus many people with disabilities are living in institutions, even though they would rather have the freedom of living at home.

So I applaud your statement and its intent, because I, too, support helping individuals with disabilities live in the least restrictive setting of their choice. I would really like to know more specifics on what sort of policies you plan to adopt at CMS in order to accomplish this goal in this very short timeframe.

Mr. McCLELLAN. I think there is a little bit of a mistranslation. We didn't say we planned to do it. This is something that it is going to take changes in legislation. The way that the Medicaid statute is set up, as you know, is that under the Medicaid statute, you are entitled to a nursing home benefit. That is the entitlement, because that is what long-term care meant in the 1960's.

What we have seen, through the waiver programs that we have supported and through the Independence Plus demonstration programs, is that we can serve more people in the home or in other settings that they prefer. We can do it at a lower cost. We can do it with better healthcare outcomes, and we can do it with better satisfaction for our beneficiaries when we move away from that

statute toward the kinds of approaches that States have adopted when they jump through all of these hoops, and go through all the regulatory hurdles to get one of these waivers approved. What we would like to see is that approach being built more directly into the Medicaid program, and that gets back to the comment from Chairman Barton earlier—

Ms. BALDWIN. Right.

Mr. McCLELLAN. [continuing] that we need to have a discussion with you about how we can do that, about how we can serve more people in a setting that they prefer. I am confident we can do it in a way that gets assistance to more individuals who need help, and at a lower cost per person, and help reduce the strains on the Medicaid programs that we have been talking about this morning.

Ms. BALDWIN. Would you like us to consider making home and community-based care a mandatory service under Medicaid?

Mr. McCLELLAN. What I would like us to do together is look at the experience we have, where we know that when States adopt these reforms, these waivers, which they have to go through a lot of work to do today, it is not the default today—

Ms. BALDWIN. Right.

Mr. McCLELLAN. It by no means happens automatically. As you said, most people on Medicaid who need long-term care services cannot choose how to get them. We need to look at the experiences we have, and find a way to build that into the program more automatically. That is something that is going to take a dialog between you and us, and I was very encouraged, as I said earlier, by the opening statements, where there seemed to be pretty strong support on both sides of the aisle that we could find a way to get to an agreement on making Medicaid more rebalanced toward personal control and spending the dollars the way that people want them spent in the program.

Ms. BALDWIN. Well, again, in terms of the discussion that we will be having in order to meet this goal, do you see recommendation of lifting the caps on the current Medicaid home and community-based care waivers, or suspending budget neutrality policy, so that again, to accomplish that goal, all that wish to live in the community are able to access community care?

Mr. McCLELLAN. Well, I think we need to deal with the reality, that as you have heard, and as I have heard from all the Governors I have talked to, that States don't have more money to spend, so we need to find ways to implement these programs that make the dollars in Medicaid go further, that serve more people at the same or lower costs. And a lot of these waivers give us some directions in how to do that. Many of the States are prioritizing how the long-term care services are used, and who they can, and want to serve first. One approach is to consider what the top priorities are for spending this money better. Another approach is to bring in some of the other ideas that have been discussed this morning, on bringing in more private funding for long-term care needs.

I think one of the reasons that this bias in the Medicaid program has persisted for so long is that it acts as a kind of rationing. There are a lot of people who don't want to be in an institution, and if you don't have a better design in the Medicaid program, a fallback is to say that is all we are going to cover. And that is a good way

to keep costs down. It is not the most effective way to spend Medicaid dollars, but it is one that we ought to try to. And by bringing in ideas like the Long-Term Care Partnership, and seeing what we can do to promote and help people understand about the benefits of approaches like reverse mortgages, I think we have got a lot better chance to help more people in a community where they need it while they are dealing with the fiscal realities that States are facing today. That is the discussion that we ought to be having this year.

Mr. DEAL. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Dr. McClellan, I hope that if we were sitting here in this committee today, and were trying to devise the Medicaid system, that it wouldn't look like what we are talking about. But have you thought about what the Medicaid system should look like. If we were to start the year 2005, and make the Medicaid system, what would it look like? What would it be?

Mr. MCCLELLAN. Well, it is a very good question, Dr. Burgess. We have done a lot of thinking about that, in preparation for this hearing, and in reviewing all the results that we have seen from waivers, one way that it would be different, as I have been talking about, is that it would focus on the needs of individuals that it is intended to serve. Medicaid needs to first and foremost focus on people who are truly medically needy. That is where the taxpayers want us to spend the dollars. That is why the Medicaid program is such an essential lifeline. It would give them, when it comes to long-term care services, much more control over how they get their services, and the support they need to use those Medicaid dollars effectively.

And the reason I can say that with a lot of confidence is that we have many cases from all of these home- and community-based service waivers, and our Independence Plus demonstrations, and some of these other approaches to provide care in the community, that give these results, that show that you can serve people more effectively, meaning they are happier, and you can do it at a lower cost per person. You can expand the amount, the number of people who are served with these approaches, and that ought to be our focus in the Medicaid program. Let us look at what is actually working to get better care to the people who need it the most, and let us build that into the Medicaid program.

Mr. BURGESS. And Dr. Holtz-Eakin, along those same lines, have you thought about what the Medicaid system should cost?

Mr. HOLTZ-EAKIN. We don't have a branding as a target estimate. I think the important thing for the committee to keep in mind is that while it may be the case that as we get older and as a Nation become better off, we will spend more on healthcare. It is simultaneously the case that the projections under current law of healthcare spending are a key part of a long-term budget outlook which threatens to be numerically unsustainable, and we have documented this in our 2003 report. It is the most pressing domestic policy matter that we see out there, and looking at long-term care in conjunction with all the other demands in the health area simultaneously is an imperative. We are thinking about the budgetary future of the United States, but also its economic policies.

Mr. BURGESS. So just for the record, say that again. It is the most pressing domestic policy issue that we face?

Mr. HOLTZ-EAKIN. Yes, it is.

Mr. BURGESS. Okay. Thank you for your candor. Well, again, I, too, have a long-term care policy. I bought it in the year 2000, because my mother told me to, and it was a good idea, and I am glad I did. One of the things that, when I looked into it, one of the things I wanted to be sure of was that I did have the ability for home care or community care, and then the other thing that I looked into is if I was—if I did the spend down and went on Medicaid, that instead of being in Denton, Texas, I would probably be in Paris, Texas, because all of our nursing homes in Denton have been closed down because of liability problems, or they are just empty shells of what they used to be. So it is hard enough to get your kids to come visit you anyway, but if you move 400 or 500 miles away, that was going to be another problem. So it was a pretty easy decision for me to buy my own policy, and just like Dr. Norwood, I have a policy that covers myself and my wife, and it is \$2,000 a year, and it is not a tremendous financial burden. Sure, there is other things I could do with that money, but it seems like we have anesthetized the American public about the need for long-term care insurance, or even to consider long-term care insurance, to even weigh it in the equation of your household basket of expenses. Most people, and in fact, before my mother told me to do it, I would have never considered long-term care insurance.

What are some of the things that we can do as we go through this process to un-anesthetize the American public about the necessity of the purchase of long-term care insurance, or at least to look into the possibility of purchasing long-term care insurance. And I guess we will start with you, Dr. McClellan, but I do want to hear, Dr. Holtz-Eakin, your comments as well.

Mr. MCCLELLAN. Well, that is a very good question. We have undertaken some steps in recent months to provide more education and support tools for people. You can see them when you visit our website. We have also been working in partnership with the administration on Aging to develop resources that people who are thinking about long-term care planning can use, and we helped fund a study that you are going to hear about a little bit later in this hearing, conducted by the NCOA, which has looked at the potential for reverse mortgages, and what people's opinions are about them right now. And I think despite all of that work, there clearly is a knowledge gap, and many people aren't thinking ahead.

As you heard from Congresswoman Wilson, a lot of people think that Medicare is somehow going to take care of this, and that is just not the case. People do need to be planning for their long-term care needs if they really want to have the kind of support in the setting that they would prefer. So I think educational activities are really important, and they ought to be part of our efforts this year to try to get to a more sustainable long-term care system.

Mr. HOLTZ-EAKIN. I guess I would offer three observations. The first is that to the extent that there is awareness, it also may be useful to have policies that are more standardized and easier for people to compare, so that they can actually do the shopping and know what they are paying for when they get it.

And it would probably be useful, as well, to remember that incentives to purchase the long-term care policy are the same incentives that basically say I would like to preserve my assets somehow, rather than have to pay them out for my long-term care. So looking at this simultaneously with the broad awareness of transfers of assets as a potential way to preserve, or having things in the home, which is not a counted asset, as a way to preserve, thinking comprehensively, and not just focusing on the long-term care market in isolation I think would be a second thing to worry about.

Mr. BURGESS. But Representative Wilson from New Mexico already pointed out that the greatest marketing effort right now that is going on is with the portion of asset protection attorneys who are encouraging people to go the other way, and protect assets, and then rely on the Medicaid system for long-term care insurance. I don't know if we can get any of these quotes up that I was given. Slide 4, I don't know if that will project for us, it was just rather enlightening, as I was glancing through these. If not, I will ask unanimous consent that we put that in the record.

"So if you want to confuse, completely confuse the Medicaid authorities, they may just approve you on the basis that they haven't got a clue of what is going on, and it looks so fancy it must be right. Just don't mention my name when you do it. This is Alex Bove, Advanced Medicaid Planning and Related Issues, National Academy of Elder Law."

So that is kind of what we are up against on the other side, and it seems to be very difficult to get that message out. Well, I just want to ask Dr. Holtz-Eakin one other thing. Along the lines of Chairman Barton, when he talked about honesty or ground rules for CBO scoring, one of the examples that came to mind, Dr. Zerhouni, I don't remember whether it was in this committee or in a private briefing, talked about a strategy for Alzheimer's. If they can get to the point where they can delay the onset of Alzheimer's disease by 5 years, the cost of taking care of an Alzheimer's patient could be reduced by 50 percent. Do you have any way of working that type of knowledge into your scoring as you go through and look at the cost of taking care of an Alzheimer's patient, for example?

Mr. HOLTZ-EAKIN. Certainly, that is how we build our estimates. We look to the research literature, and particularly, the peer reviewed research literature to give us consensus estimates of, in this case, medical impacts, other areas that would be different impacts, look at the cost implications that would come from changes in those medical treatments that are necessary. And then, build that into estimates of legislation to the extent that the legislation would actually deliver them, and often, there are tough calls about how it would be implemented, and the kinds of administrative procedures that would put the legislation into place. That would be Mr. McClellan's domain. Then there are also some things that people often forget, which is to the extent that these are ongoing medical improvements that would happen anyway, they are usually in our baseline, and as a result, people don't get credit twice for having them in the baseline, and then proposing legislation.

And particularly in these areas, the time horizons often work against proposals. Spending is usually up front, medical improve-

ments are often well down the line, outside five or even 10 year budget windows, and as a result, there is a mismatch. But the process—

Mr. BURGESS. So the short answer is no.

Mr. DEAL. The gentleman's time has expired.

Mr. HOLTZ-EAKIN. But the information goes into it, and I want to emphasize that that is standard business.

Mr. BURGESS. All right. Thank you.

Mr. DEAL. We have got a vote going on that is going to be for several votes, probably four or more. Mr. Allen, would you like to proceed with your questions?

Mr. ALLEN. I would, Mr. Chairman.

Mr. WAXMAN. Are you going to bring them all back, so we can—

Mr. DEAL. Well, I was hoping we could finish with this panel and dismiss them, but we still have a couple of others that have questions. You both have questions?

Mr. ALLEN. Mr. Chairman.

Mr. DEAL. I guess we are going to—we will have to bring them back. Would you like to go ahead and start?

Mr. ALLEN. I would. Well, Mr. Waxman, will you be able to come back or not?

Mr. WAXMAN. Well, my problem is that I have to be at another committee, and I think that the chairman probably wants to dismiss this panel, and you and I are the only ones left for a 5-minute period, so let us—

Mr. DEAL. I think we are going to have to have them back—

Mr. WAXMAN. [continuing] be brief.

Mr. DEAL. [continuing] unfortunately Mr. WAXMAN. What is that?

Mr. DEAL. We are going to have to—

Mr. ALLEN. Well, I would defer first to Mr. Waxman, and then do my questions after his, if that is—

Mr. DEAL. Well, we recognize Mr. Waxman then.

Mr. WAXMAN. Thank you very much. Unfortunate timing. Dr. McClellan, you said you wanted to eliminate the institutional bias in the Medicaid program, and you have a New Freedoms Initiative, which is intended to move individuals with disabilities from institutions to the community. Is this proposal a demonstration or a broad program for which all individuals with disability would be eligible?

Mr. MCCLELLAN. This is a program that would provide funding at the level of \$1.75 billion over 5 years, with \$350 million available for each year. It would be enough funding for a number of States to do it. As always, when you have new reforms, if you can give them a boost at the beginning, it is more likely that you will be able to get other States to come along later. We have seen the—

Mr. WAXMAN. Well, is this going to cost, as I understand it, \$2.9 billion over the next 10 years?

Mr. MCCLELLAN. We are authorizing \$350 million a year for the next 5 years, and I think the projections that the actuaries have done suggest that some of that spending may occur a little bit

later, but if it occurs sooner, we are fully supportive of that, too. We would authorize—

Mr. WAXMAN. Now, this is also going to be in the context of a proposal to cut \$60 billion from Medicaid. According to your budget, you propose to cut \$6 billion out of Medicaid by block granting administrative costs. Is that right?

Mr. McCLELLAN. We propose reforms in administrative costs, which as you know, have been one of the most rapidly growing components of the Medicaid program.

Mr. WAXMAN. But this—you are going to get \$6 billion out of that.

Mr. McCLELLAN. I think it could be. There are other versions of administrative cost reform proposals. CBO has scored some that would limit the administrative costs increases to 5 percent per person over—

Mr. WAXMAN. But isn't it true that part of Medicaid administrative cost goes to survey and certification of nursing homes in which individuals with disabilities reside?

Mr. McCLELLAN. Some of it goes to survey and certification. There also, as you know, is Federal funding that we provide for some of the nursing home survey and certification activities.

Mr. WAXMAN. In your budget, you propose to cut more than \$11.7 billion from targeted case management. Is that correct?

Mr. McCLELLAN. The fiscal year 2006 budget reduces spending on targeted case management by \$8.2 billion over 10 years.

Mr. WAXMAN. And isn't it true that individuals with physical impairments and limitations, like blindness and spinal cord injury, severe mental or emotional conditions, including mental illness, and other disabling conditions, such as cerebral palsy, cystic fibrosis, Down's syndrome, and mental retardation, muscular dystrophy, autism, spina bifida, HIV/AIDS, rely on targeted case management for their care?

Mr. McCLELLAN. There are other programs that provide care coordination and support. For example, in our Money Follows the Person demonstration—

Mr. WAXMAN. Well, there may be other programs, but doesn't a lot of that money that is targeted case management go for those people?

Mr. McCLELLAN. It also goes for services provided in prisons, in schools, in areas that are outside of the primary responsibility of the Medicaid program, where there are other Federal financing sources that are clearly more appropriate.

Mr. WAXMAN. I want to point out my colleague, Dr. Burgess, I just went through people with a lot of disabilities. Those people can't get long-term care insurance. If people have MS, even it is not active, they can't get—long-term care insurance provides underwriting to exclude people from being able to buy it. I just think we have to keep that—

Mr. BURGESS. Will the gentleman yield?

Mr. WAXMAN. I won't, because of the time pressure. But I just want to point that out. It is a problem when we look to private insurance, but by my calculation, Dr. McClellan, while you propose increasing spending for individuals with disabilities through a few demonstration projects to the tune of \$1.4 billion over 5 years, you

then actually cut \$17.7 billion out of areas in Medicaid that they have—that will have a particularly negative impact on individuals with disabilities.

I find it hard to believe we can make improvement in the lives of individuals while cutting such a significant amount of funding for the program that serves so many people with disabilities. Does the administration favor requiring a person to take out a reverse mortgage on their home before they can receive long-term care under Medicaid?

Mr. McCLELLAN. We do not propose any such requirements. What we have proposed is making sure people know about the options that reverse mortgages can provide, since there is a lot of potential for helping people get care where they want it and how they want it through mortgages.

Mr. WAXMAN. So, you wouldn't mandate it. Does the administration favor a requirement that a person have a long-term care insurance policy as a condition for eligibility to receive long-term care benefits from Medicaid?

Mr. McCLELLAN. We haven't proposed a requirement. We have proposed the Long-term Care Partnership program be reinstated by Congress, because that allows people to use a long-term care insurance policy to protect their assets, and also keeps Medicaid funding reserved for people who truly can't afford to pay.

Mr. WAXMAN. As a man familiar with Medicare, Medicaid, economics, and human nature, do you think people refuse to go out and buy private insurance because they are calculating on the fact that Medicaid is going to be available to them when they have long-term care insurance, or do you think it is more likely that they don't anticipate ever having those needs, they think Medicare maybe already covers it, they have other pressing economic demands on them, and they are not well-informed about these policies, and these policies exclude people who have underwriting problems, and there are no uniform standards in terms of inflation and coverage and all of that? Do you think that Medicaid is a reason why people aren't buying these policies?

Mr. McCLELLAN. I think that there are a number of reasons like the ones that you have described, but all that leads to the conclusion that we need to change the current system. Right now, three quarters of the—

Mr. WAXMAN. Change the current system of Medicaid?

Mr. McCLELLAN. Change the current system in Medicaid, change the current system in providing support and education for people to use these alternatives to Medicaid to finance the long-term care that they want in the way that they want it. As you said, a lot of people don't know about it. If we did a better job of informing people and making these options available, and showing how they can help, then that can reduce the pressure on the Medicaid program. When three quarters of the people in nursing homes are getting—

Mr. WAXMAN. I don't disagree with you, but—

Mr. DEAL. Gentleman, your time has expired. We can—

Mr. WAXMAN. My time has expired. Well, he didn't—

Mr. DEAL. [continuing] speculate on what people's motives are—

Mr. WAXMAN. [continuing] answer my question.

Mr. DEAL. Well, you asked him—

Mr. McCLELLAN. Well, I tried, but—

Mr. DEAL. [continuing] to speculate on the human mind, and their motivations. That would be great speculation as to what people's motivations are. We are going to unfortunately have to adjourn for another series of votes. Gentlemen, I had hoped that we were going to be at the point we could dismiss you, but I do have a couple of other members who have already gone to vote, and asked if you would stay for their questions when we return. Hopefully, we can wind your portion up very quickly when we get back.

Thank you. We stand in recess.

[Brief recess.]

Mr. BILIRAKIS. [continuing] a reform of the system. I don't know what would be. But let me ask you, Dr. McClellan. If we don't enact real reforms, do you expect these trends to continue? I guess I am asking the questions, and I suppose I know the answer has to be yes, but maybe you could explain that a little bit.

Mr. McCLELLAN. I think the answer is yes, and that is something we are hearing, as you said, uniformly from Governors in both parties, from all over the country. Their view, and the view of many is that the current program just isn't sustainable. And there will be reforms taking place, whether this committee acts or not. If you don't act, you are going to see more of the same, more benefits being reduced, optional populations being dropped, innovative approaches like home- and community-based services being limited, and payment rates being cut to the point that people don't have access—

Mr. BILIRAKIS. So we are talking about reform is necessary to keep this from becoming a trend all over the country. Is that correct?

Mr. McCLELLAN. We need to give the Governors and the Medicaid program better tools to get high quality care to patients without spending more money. And I think the good news is that there is some clear evidence of ways in which we can do that, and some of the best examples are these home- and community-based programs that ought to be a more integral part of the Medicaid program, and I hope we will find a way to all work together to use these proven approaches, these evidence-based approaches—

Mr. BILIRAKIS. Now, you have indicated, Doctor, and we have worked together on healthcare for many, many years, and you are a medical doctor, and I know that you care about patients. And additionally, you have shown a real caring over the years. So I would like to think that whatever it is we are going to be addressing here, it is always keeping the beneficiaries in mind. You know, we don't want to degrade them in any way, and force people out of the system, and somebody made the comment that these—they are being forced to take reverse mortgages, I am not sure whether that came out the way it was intended to come out, and as far as I know, they are not being forced to do that. If they are, I would like to know about it.

Mr. McCLELLAN. That is correct, and you know, I appreciate your comment, and the reason that I feel pretty passionately about this is because I have seen not only my own patients, but in this

job, I get a chance to meet with groups like the National Center for Independent Living, ADAPT, and others who have firsthand patient and person-based organizations for the people who actually want to get better care in the Medicaid program, and they feel very passionately about that. That is the main reason that we ought to be here taking action on this issue—

Mr. BILIRAKIS. Well—I mean—I think I have made it clear over the years, I won't be a party to hurting people who are deserving, as far as cuts are concerned and whatnot. I mean, I think the word cut is an inappropriate word. It is savings, but—

Mr. MCCLELLAN. Right.

Mr. BILIRAKIS. [continuing] the fact of the matter is that hopefully, those savings will result in more people, or less people being dropped and more people maybe even coming aboard.

Dr. Holtz-Eakin, why—you know, we are slaves here legislatively to CBO, to your scoring. That was set up, I guess, by the Congress, so it is what we did to ourselves, and yet, I know there has got to be, well, I know I am running out of time here. I guess basically my question is very quickly, is why is there such a difficulty in reconciling what you all think regarding scoring versus what we think regarding scoring? Now, I realize that maybe you are more the experts, and we are in an ivory tower, and that sort of thing, but you know, we—a long time ago, we thought that there should be dynamic scoring, and we have taken over the Congress, and still, we don't have dynamic scoring.

The Democrats had the same problems with scoring as we have. A lot of things that we talk here about some of the things that can be done here on long-term care and whatnot, chances are CBO would probably not give us any credit for any savings, if you will, in that regard.

Very quick answer, because I know my time has expired.

Mr. HOLTZ-EAKIN. Well, some quick points in no particular order. First, on dynamic scoring. In—three years ago, CBO put out a full scale analysis of the President's budget proposals, that included all the feedbacks, including macroeconomic feedbacks, that was in the context of the dividend proposal. We have continued to do that every year. That—we have worked with the Budget Committees to make sure that that is useful to the Congress, and we are working with them to see if there are other areas where they would like more information of that type.

On general issues, and why reasonable people don't see eye to eye on budget scoring, I think there are a couple of things that often come up. No. 1, differential information. That is one that can be fixed. Any time a member or staff has information that they think is superior to what we have, we encourage them to bring it to us to help us improve the scoring process.

Second would be the degree to which we are providing a consensus estimate versus one which might be a deeply held but non-consensus estimate on the part of a member. I think that is often a source of disagreement, and I think it is a legitimate source of disagreement.

And then the final is the degree to which we are capturing things that are in the legislation. And in the end, we score legislation. Often, members, in their heads, score their intent, and there are

cases where the legislation doesn't match their intent, either because it requires implementation, it doesn't show up in the budget window, or it—there are just drafting problems. In any of those circumstances, I think the No. 1 thing is to make sure that neither side sits in isolation and stew about it. We need to have a good dialog and open communication to make sure we improve.

Mr. DEAL. The gentleman's time has expired.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I am sorry it took—

Mr. DEAL. Sure. Mr. Allen is recognized for 5 minutes.

Mr. ALLEN. Thank you, Mr. Chairman, and thank you both for being here. Comments and a couple of questions.

You know, I noticed the language in your testimony, Dr. McClellan. I am not going to attribute to you. I am sure someone else is paid to come up with this. The New Freedoms Initiative. The Money Follows the Person Initiative. The Real Choice Systems Change Grants. I mean, then you apply it to Maine, and I do appreciate the recognition of what Maine has done, but you began by saying to ensure people know about their options before entering a nursing home, this is your testimony, Maine required preadmission screening and periodic reassessment for all nursing home residents.

We did that. It isn't about choice, really. It is not really about choice. It is about two things. No. 1, we constricted the number of nursing home beds over a period of time. We tightened up the certificate of need process, and there was a lot of pain in the nursing home industry in Maine over those years. It certainly wasn't a choice on their part. But beyond that, it was designed to move out of nursing homes those people who could be served either in a community-based setting or in their own homes. It was—and so, when I said earlier that people in nursing homes in Maine today belong in nursing homes for sure, I really meant that.

We have done a lot between 1995 and 2002. This is just reading from your prepared testimony. The number of Medicaid nursing home residents in Maine decreased 18 percent, while the number of people receiving Medicaid and State-funded home and community-based services increased by 78 percent. We have made the transition that I think you are urging all of us to make. But when I look at the President's budget, and what is proposed, we are already, Maine is already facing a State Medicaid shortfall of \$70 million for the next 2 year cycle, due to the FMAP going down 2 percentage points.

One projection is, under the President's proposal, we would lose \$307 million in Federal funding over the next 10 years, and you were saying, no, we need to find better tools without spending more money. This is healthcare, and my view is we are going to spend more money, because we have an aging population, and that just goes with the territory.

But my first question is, given States that have already made the effort to move people out of nursing home care wherever it is possible, into home or community-based care, is that going to affect, in any way, the amount of reductions that we are expected to take compared to other States, with respect to the President's proposals?

Mr. MCCLELLAN. Just first let me say that I appreciate your pointing out Maine's experience, where you have seen, as you

pointed out, a 17 percent increase over 7 years, while more people are being served with long-term care assistance, and they are getting better results.

If that were the rule and not the exception in Medicaid, we would be in a lot better shape, in terms of the overall sustainability of the program. So, that is what we would like to see happen in a lot of other States, and it is not happening right now around the country. Most Medicaid beneficiaries do not have a choice and are not asked these questions regularly about how they want to get their care.

With respect to what the President's budget proposals mean for Maine—

Mr. ALLEN. Would we catch a break?

Mr. McCLELLAN. Well, you are going to get some savings, you know. Some of the proposals that we have made for addressing the overpayments in prescription drugs and the asset transfer proposals are actually savings for States as well, and with respect to the intergovernmental transfers, we do want to make sure that we are implementing them in a way that doesn't have adverse impacts on populations that are intended to be served.

And once again, there is good experience from which to learn. We have been working with lots of States to address and eliminate improper intergovernmental transfers, when we have the authority to do so under current law, and we have been able to do that successfully with most States. So we need to keep moving in that direction to spend the dollars effectively, and do it within the law.

Mr. ALLEN. But if I can go back, improper intergovernmental transfers is one way, what you call improper, is one way that we have been able to care for as many people as we can, and I come back to what Mr. Bilirakis said. You know, it feels sometimes as if the administration has, you know, is fixed on the cost number, but isn't fixed on the beneficiaries. You know, we have got a healthcare system in this country, and that is the problem. I mean, the wheels are coming off this employer-based system, I think, and so we are struggling with Medicaid, particularly in a down economy with people losing their jobs, you know, and yet, there is no recognition that in the best of worlds, it won't be long-term care insurance or reverse mortgages. Something much more fundamental needs to happen here, which I think is a combination of efficiency and more revenue, but you don't get there without more revenue, but you have to have the efficiency as well, and that is—well, my time is up, but if you maybe have a quick comment.

Mr. McCLELLAN. I would agree with you. The first priority has to be what is best for beneficiaries, and again, that is what motivates our proposals on these reforms in Medicaid long-term care systems.

They help more beneficiaries live a better life, and that ought to be the first thing that we care about. It just so happens you can do these things in a way that doesn't increase Medicaid spending. We have overwhelming evidence, including evidence from Maine, that these approaches lead to better results for more people, without increasing funds. If every State had only seen their Medicaid spending on long-term care go up by 17 percent over the last 7 years, we would be in much better shape than we are today.

Mr. ALLEN. But Medicaid spending is still rising in Maine.

Mr. McCLELLAN. Well, right, and it is projected to rise under our budget, too—

Mr. ALLEN. Yeah.

Mr. McCLELLAN. [continuing] by over 7 percent per year. We just need to make sure that money goes as far as possible in helping as many people who really need it as possible.

Mr. ALLEN. Thank you.

Mr. DEAL. The gentleman's time has expired. Ms. Myrick is recognized for 5 minutes.

Ms. MYRICK. Thank you, Mr. Chairman. Thank you both for being here. And Dr. Holtz-Eakin, I have a question for you regarding the cost of long-term care. We all know it is going to go up. I think we are kidding ourselves if we say it is not. And what appears to be a declining availability of donated care. I happen to be one that thinks that is going to continue to happen, because of societal changes that have taken place from the way it used to be years ago, when everybody helped one another.

My concern, and I would like you to, just to expand a little bit on some of the implications to that on our tax burden on the citizens and on the States, as were talking about before. If we don't shift to other utilizations, like greater utilization of long-term care insurance, private long-term care insurance.

Mr. HOLTZ-EAKIN. Well, I think that the outer bounds, you could pull out of the numbers we presented, and—doing arithmetic in my head is a dangerous thing, but the value of the donated care is hard to pin down. It has ranged from \$50 to \$200 billion in recent years. But suppose we picked \$100 billion as the value of that, and suppose that by whatever mechanism, it was translated to public sector budgets.

That would be spending. Once it was spent, it would have to be financed somehow, and in the long run, that will mean higher taxes. If it is in Medicaid, \$56 billion of that would be the Feds. The remainder would be at State and local governments, and you know, probably not 100 percent of it would show up on the government, but you could imagine a third, maybe a half, and that is a substantial additional need for resources, and it would show up in taxes in the long run.

Ms. MYRICK. Well, it just to me proves the need that we have got to do something. We can't go down the same road we have been going down, and expect to get a different result. Appreciate it.

I yield back my time, Mr. Chairman.

Mr. DEAL. I thank the gentlelady. Mr. Green, do you have questions?

Mr. GREEN. Thank you, Mr. Chairman. And Dr. McClellan and I agree that many individuals in need of long-term care would rather be at home, and we have that example in Texas, are in their communities and institutional setting. Your testimony reference our State of Texas, which has taken measures to allow individuals to move from institutions to the community, and yet, in our last Texas legislative session in 2003, they set limits on the individual costs of care for individuals. It is generally recognized that the cost of long-term care exceeds Medicaid reimbursements to the tune of \$4.5 billion annually, and if you are in an institutional setting, and

there is a cap on it, these costs are absorbed by the provider, you know, that. However, in the home and community setting, the low income families are left holding the bag. Because they don't have that ability, they don't have \$4.5 billion. They are typically—they are taking their mom or their father in, or their aunt and uncle, and I worry that the only choice they really have will be between limiting either the scope or the quality of the care in an effort to make the ends meet.

Does the President's plan to expand home and community-based services safeguard Medicaid beneficiaries from that situation, and ensure that States will provide our community-based Medicaid patients with quality care?

Mr. McCLELLAN. Absolutely. We have requirements now in place that we have strengthened in the past year for monitoring the quality and the safety of services provided in home- and community-based waiver programs. States are required to give us an update on those waivers on an ongoing basis, and every waiver that we get now incorporates these kinds of quality assurance and quality improvement steps into the actual waiver application, and to the actual waiver template, and I do think that it is important to look at how these systems actually perform. We need to keep a close eye on how satisfied beneficiaries are and whether they are really getting a better quality of life, which is absolutely our intent, and can be achieved.

In fact, we have recently reorganized our Center for Medicaid and State Operations to have one whole office that focuses on the performance of the Medicaid program, and specifically, the performance of these kinds of waivers. So we are monitoring that more closely than ever before. It is an important part of a successful home- and community-based waiver program, and we will keep a close eye on it going forward.

Mr. GREEN. Okay. And this is a question for either you or Dr. Holtz-Eakin, and I would like to talk about the Medicaid's Long-Term Care Insurance Partnership, as an incentive to folks who purchase long-term care insurance. If the panel could shed some light on whether the partnership has actually created overall savings in Medicaid, and if so, how much, and to what extent has this program encouraged specifically low and middle income individuals, and those most likely to become Medicaid long-term beneficiaries, to purchase that long-term insurance. Also, is there any Federal mandate that these long-term policies under these partnerships contain some type of minimum standard coverage, so people will know what they are buying?

It is for both of you really.

Mr. McCLELLAN. Just a few comments. There are four States that adopted this before the Congressional moratorium was imposed, and I think one important bottom line is that for people who use these approaches to purchase long-term care policies, it does work. They don't end up going on Medicaid. It would obviously be more helpful if we could expand this program more widely. I think ideas like you are talking about for giving people advice and support about how to use these long-term care insurance policies to protect their assets, and get more control over how they get long-term care services, should be an important part of the expansion

as well. It is a very important way to help protect people's assets and shift the burden from Medicaid to the private sector.

Mr. GREEN. Dr. Holtz-Eakin, can you—I understood there was a concern that these partnerships actually cost Medicaid more money.

Mr. HOLTZ-EAKIN. When we priced the President's budgetary proposals in this area, we came out with what was a \$45 million cost, a modest cost at best, but the key analytic issue is the degree to which the partnership policies draw their participants from those who would otherwise have simply bought a private long-term care insurance policy. And there is lots of survey evidence from, for example, participants in Indiana, that that is, in fact, how they looked at it. I could have bought my own long-term care insurance policy, and I chose this partnership one instead. If so, you won't get savings from that avenue. That, in fact, puts people on Medicaid more quickly. The other possibility is they come from a population that would otherwise not have any insurance whatsoever, in which case there would be savings.

So the key issue is, where is the partnership policy drawing its participants, from those who would buy insurance on their own, or those who would be uninsured? Our estimate, based on what we know about the current participants, and those who were likely to be eligible, was that on balance, it would break so that it transferred people from the private insurance market to the partnership.

Mr. GREEN. To the partnership. And that is a concern, because again, low income and middle income people have finite resources, but it needs to be reasonable enough that they can do it, and yet, still know what they are buying, so they don't pay for 5 years, and then, you know, 5 years later, they say I can't afford it, and so they drop it, and so, they've got nothing. But that is why there needs to be some kind of minimum standard, like we do for supplemental policies for Medicare.

Mr. HOLTZ-EAKIN. And if I could just add, I think this is part of the long-term goal of getting more people into long-term care insurance if they have got the means to do so. You know, people who are already in their seventies or eighties, and who are really on the edge of going—of needing these kinds of services aren't the main target for this program. It is people who are baby boomers, who may be coming into needing long-term care services over the next five or 10 years, so you are not going to see the short-term impact as much as you can make the Medicaid program more sustainable for the long term. If we have got the middle class buying and providing for their long-term care services more on their own, and this is one of a number of strategies to do that.

Mr. GREEN. Okay. Thank you, Mr. Chairman.

Mr. DEAL. Mr. Shimkus is recognized.

Mr. SHIMKUS. Excuse me. Thank you, and I appreciate you all coming in, and your patience, and I also thank the patience of the second panel, who we will eventually get to. But I wanted, since I had this time, I wanted to address—this is an important issue, these are important questions, and you know, actually, I am really proud of the Congress to start stepping into generational challenges, and grab a hold of some of these contentious issues, and they will be politicized, and they will be challenged, but I mean,

that is what we are here for, to take on these hard choices. So I applaud the debate and the concerns.

I have been involved for quite a few years now with the disability community, and am the cosponsor, along with my colleague, Danny Davis, on My House or MiCASSA, which is very similar, but more expansive of the—than the President's New Freedom Initiative. And I—so I really applaud the President. And I know the disability community is very excited about it, because it is going to give us a chance to prove the merits, and then, hopefully, we can roll it out to a bigger—one of the concerns the committee has, as we try to address this, is they use the terminology woodworking, and from my understanding, it addresses people who do not seek institutional care, but are using their own dollars to stay home, that then might, if the—as we would like, if the money follows the individual, there may be more demand on the dollars. Are you familiar—I mean, am I reading this analysis correctly? And why don't we—Dr. McClellan first, and Dr. Holtz-Eakin.

Mr. MCCLELLAN. Well, there certainly have been concerns raised about woodworking, but that is why, I think, as you said, the committee and the Congress need to take this on in a more comprehensive way. You know, I think we are just not doing justice to long-term care policy in this country, when one of the best justifications we have for keeping in place a system that doesn't give individuals on Medicaid with a disability control is that gosh, this is the only kind of benefit we can provide that won't attract more people.

I mean, it is the wrong justification and the wrong way to be providing long-term care. Certainly, the woodwork effect is something that we should be concerned about, but as we have seen, from many of the waivers that have been implemented, including experience in Arizona, there are ways to implement these programs that serve more people, that give people a choice, and that are manageable from a State budget standpoint.

I mean, you are absolutely right that we are not going to make a difference in this problem if we come up with some approach that is going to cost States a lot more money. They don't have more money right now, but we have got enough evidence that these kinds of reforms can be done in a way that works, and that serves more people more effectively. And using the woodwork excuse is just not good policy.

Mr. HOLTZ-EAKIN. I think the recent evidence is this is an important part of policy design. I forget the exact numbers, but within Medicaid, home and community-based care in recent years has grown about 11 percent. Nursing home growth has been much lower, and that has largely to do with the numbers of bodies involved. So in designing a policy, you have to worry about those who are desirous of being in their homes, and who might now be in donated care moving on to a program like that.

Mr. SHIMKUS. And Dr. Holtz-Eakin, when, in your formulary, in your statistical analysis, are you taking into consideration the return on the investment, and the ability of the disabled community to work and be productive, because they are staying at home, versus institutional care.

Mr. HOLTZ-EAKIN. In terms of direct feedback, so I am—

Mr. SHIMKUS. Obviously, they could be in essence, then, working. They could be earning income, other issues there.

Mr. HOLTZ-EAKIN. It depends on the context. We could look at particulars, but we do try to trace through comprehensive, the impacts of any bill, and if that were to allow the disabled to work more, at some cost, but with some other implications for the budget, we would try to track those as well.

Mr. SHIMKUS. Because there may be a revenue generator that might offset expenses. I am not sure. I am not a mathematician, or a—

Mr. HOLTZ-EAKIN. But the details, we would be happy to work—

Mr. SHIMKUS. Thank you. Mr. Chairman, the last thing. That long-term care insurance, if offered, would it offer for long-term institutional care and for home care?

Mr. McCLELLAN. Yes, the policies that are around today give people a lot of flexibility about how they spend the money, and that is one of the nice features of it. Unlike Medicaid, which by statute, says institutional care, you can have more control over how you get long-term services. That is why it should be such an important part of financial planning for baby boomers and people who are approaching older ages.

Mr. SHIMKUS. Well, and that is why I have—in support of the MiCASSA legislation, or the New Freedom, it does provide individuals more freedom to make the choices on their own. You are saying long-term care insurance would do the same thing.

Thank you, Mr. Chairman. I yield back my time.

Mr. DEAL. I thank the gentleman. Mr. Strickland, do you have questions?

Mr. STRICKLAND. Thank you, Mr. Chairman. Dr. McClellan, following up on your interaction with Representative Allen regarding intergovernmental transfers, it would be helpful to us, and I am asking if you would be willing to provide us in writing the specifics of your policy regarding intergovernmental transfer. Would you be willing to do that, sir?

Mr. McCLELLAN. Well, we have, I know, provided some specifics already in the context of the budget, and that is what was estimated by our actuaries, and that is what the Congressional Budget Office used in their scoring. So we can certainly provide that level of detail, and I know we want to continue to have discussions with you and your staffs about exactly how these policies can be implemented. So, we will continue that, too.

Mr. STRICKLAND. Great. It would be also helpful if you could include in anything you provided to us what assumptions you are using in the development of your policy. That would be very helpful to us.

Mr. McCLELLAN. Okay. I can tell you as a general matter, that our actuaries don't do State-specific analyses. It is more of a calculation burden with 50 States, and all kinds of different programs and they do all they are able to do. They typically try to do as sophisticated models as they can with the resources we have, but that means, you know, looking at the different types of States and different categories, so I will try to get some of those assumptions to you.

Mr. STRICKLAND. I mean, if there could be some clarity, so that there, you know, are some specific understandings as to—

Mr. McCLELLAN. Well, I appreciate that—

Mr. STRICKLAND. [continuing] as to what policies—

Mr. McCLELLAN. [continuing] is important. We need to get actual legislation.

Mr. STRICKLAND. Thank you, sir. And I have one question, but it is a little long, and the answer may be able to be short. But I wanted to ask you about the Family Opportunity Act, a bill that would allow families with disabled children, that may have incomes that are slightly above the Medicaid level, to buy into Medicaid coverage, so that their children would have access to the needed services that may not be readily available to them through any kind of affordable insurance coverage, and that being the case, then Medicaid becomes pretty much of a lifeline to these families. The administration did not include, I think I am right in saying, the administration did not include any funding for the Family Opportunity Act in its fiscal year 2006 budget, in spite of the fact that last year, the administration supported combining the Money Follows the Person with the Family Opportunity Act as a legislative initiative. Now, the chairman and the Ranking Members of the Energy and Commerce Committee, and I believe the Finance Committees worked together to draft the proposal. Instead, it seems, you know, from my vantage point, that the Medicaid program is going to be cut by \$60 billion or so, and the administration has proposed cutting some of the very services that individuals with disabilities would need, targeted care case management, for example, which would help coordinate the care of a special needs child with multiple needs.

Now, this legislation, as you know, has very strong bipartisan support, and has had for many years. Some of us were disappointed, given that, to see that the administration seems not to be willing to continue its support for this positive legislation. So, my question to you, after that long introduction, is does the administration continue to support the Family Opportunity Act? If it does, can you explain the lack of funding in the administration's budget for this purpose?

Mr. McCLELLAN. Well, Congressman, you are right. We didn't include new funding for the Family Opportunity Act in our budget. We have worked with States and made clear to States that they can use Medicaid waivers or SCHIP funds to provide the kinds of benefits that are included in FOA, but what we did last year was the same thing. We didn't have funding in our budget for the Family Opportunity Act. We did have support for a version of Money Follows the Person, and as you said, we all started working together, and we came up with an overall package that included these two important legislative proposals, that did have, as you said, considerable bipartisan support. We looked for ways to fund those recognizing that States don't have new money to contribute to Medicaid and that we have a tight Federal budget situation as well, and we made a lot of progress. We are open to that kind of bipartisan process again, where all of us work on the initiatives that are important to us, and we make progress together in getting

it done. So I hope we can use the progress that we made last year as a model, and keep building on it this time around.

Mr. STRICKLAND. Okay. My time is up. I would like to follow up, but maybe we can do that at some other time.

Mr. McCLELLAN. Yes, and I would be glad to follow up with you and your staff on this issue.

Mr. STRICKLAND. Thank you, sir.

Mr. McCLELLAN. It is an important one.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. DEAL. Well, thank you gentlemen again for your patience, and for being with us today. We do appreciate it. We regret that it dragged on too long, but you are very kind to give your answers. We have some members who will be submitting written questions to you, if you could respond to those in writing as well.

Thank you very much.

Mr. McCLELLAN. Thank you very much.

Mr. HOLTZ-EAKIN. Thank you.

Mr. DEAL. We will now call up the second panel. We are having a double header here today. Thank you for waiting around. I will introduce the panel, and then, we will begin immediately with your comments. Mr. Lee Page, who is the Associate Advocacy Director with the Paralyzed Veterans of America. Ms. Kathryn Allen, the Director of Health Care, Medicaid, and Private Health Insurance Issues of the U.S. Government Accountability Office. Ms. O'Shaughnessy, who is Specialist in Social Legislation, Domestic Social Policy Division of the Congressional Research Service. Ms. Karen Ignagni, is that right? Okay. It is pretty close, anyway. It is good for a Southern drawl it. It helps. President and CEO of America's Health Insurance Plans. Mr. Stephen Moses, who is President of the Center for Long-Term Care Financing. Mr. Bernard Krooks, who is an attorney with Littman Krooks. And Ms.—Dr. Barbara Stucki, who is Project Manager of the National Council for the Aging. And Ms. Jennie Chin Hansen, who is the Board of Directors of the AARP. And Dr. Feder, who is the Dean of the Public Policy Institute at Georgetown University.

Ladies and gentlemen, we are pleased to have you with us, and thank you, once again, for your patience, and Mr. Page, we will begin with you.

STATEMENTS OF LEE PAGE, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA; KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE, MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; CAROL V. O'SHAUGHNESSY, SPECIALIST IN SOCIAL LEGISLATION, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE; KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS; STEPHEN MOSES, PRESIDENT, CENTER FOR LONG-TERM CARE FINANCING; BERNARD A. KROOKS, LITTMAN KROOKS LLP; BARBARA STUCKI, PROJECT MANAGER, THE NATIONAL COUNCIL OF THE AGING; JENNIE CHIN HANSEN, BOARD OF DIRECTORS, CLASS OF 2008, AARP; AND JUDITH FEDER, DEAN, PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Mr. PAGE. Okay. Thank you, Mr. Chairman, and thank you, other members of the committee. I really appreciate the opportunity to be here today to talk about this very important subject. Again, my name is Lee Page, and I am an Associate Advocacy Director for PVA, which is Paralyzed Veterans of America. It is a national Veterans Service Organization dedicated to meeting the needs of its members, which are all veterans of military service with spinal cord injury or disease. I also serve as a co-chair of the Long-Term Services and Supports Taskforce of the Consortium of Citizens with Disabilities, CCD, and then also work very closely with a number of consumer-led grassroots organizations whose mission is to work for long-term services and supports.

We have had a very interesting morning this morning, listening to a lot of different comments, and it is—all sounds very enlightening and good news to me, in reference to the way everyone is engaged on this topic and subject. But what I will focus on in my comments is mainly people with disabilities and how they interact with the Medicaid system. That means non-elderly people that are 65 and younger people with disabilities, and those who are non-veterans also.

The first thing I would like to say is that, to echo, which I have heard a lot of today already, is that I believe we need to improve and expand access to community-based long-term services and supports. Currently, Medicaid has a spending bias based on a 1965 medical model that refers 70 percent of funding toward the institutional settings, and institutional care, which only allows 30 percent for community or home-based long-term care services. And here we are at the dawn of the 21st century, and 15 years after the ADA was passed, and people with disabilities are being integrated into all aspects of society, and yet, we have certain policies that were being debated and possibly implemented that will actually send people back into isolation.

In order to reverse this, I believe the real and lasting progress in this regard will be made only if Congress protects the fundamental structure of this program, Medicaid. Critical features of Medicaid that must be protected include an enforceable individual entitlement to coverage, a strong Federal State partnership, a Federal—which guarantees—which the Federal Government guarantees that will match State spending, no matter how many people

are in the program, or how many it serves, or how costly the care is to those individuals.

Critical consumer protections that ensure that with, that ensure that all Medicaid beneficiaries have the right to be treated equally, and have the right to receive Medicaid covered services when they are medically necessary. Recently, we have heard a lot of talk about references of flexibility to be granted to the States, and that is a very interesting subject, because the way that disability interprets the word flexibility, unfortunately in the long run, ends up being a little bit discriminatory toward those people with disabilities. What I mean by that is saying that the flexibility this proposed would permit States to make arbitrary distinctions between Medicaid beneficiaries on the basis of whether they fall into a mandatory or an optional category. This has nothing to do whatsoever with the level of disability, the need for services, or any other factor that justifies desperate treatment.

Furthermore, this also calls, this flexibility would permit States to ignore current Medicaid rules that ensure that services can be delivered fairly, such as requirements that benefits must be compared across beneficiary groups, and since Medicaid service is provided only when they have been prescribed by a qualified health professional. So basically, the flexibility could, in some instances, take away care that has been prescribed.

Furthermore, the majority of Medicaid spending for people with disabilities falls into the optional services. What we consider optional, what, you know, what the States may consider optional services, Medicaid administrators may—might consider them optional services. People with disabilities basically depend on those services to be independent and fully participate in the mainstream of societies.

Example is, say you have got a 35 year old man who has schizophrenia and basically has to have prescription drugs three or four times a day to maintain his recurrence of symptoms, or he would be—end up—be put back in the institution. Or a 25 year old woman who has CP or muscular dystrophy, or some other degenerative disease that she would need a wheelchair or power wheelchair in order to get from point A to point B, which would include going back to work part-time. Or a man who is 30 years old who has sustained a spinal cord injury, result in quadriplegia, would need attendant care services, such as bathing, getting dressed in the morning, and transferring in and out of his wheelchair or transportation in order to get him to go back to school, or to participate in the mainstream of society. That is just some of the issues.

I would like to turn, also, toward, you know, Medicaid as its role in providing long-term services. Let us see. We know that Medicaid is the largest source of funding for long-term care. The—and unfortunately, the private insurance market generally does not provide long-term services. Medicare's coverage for long-term care services is very limited. People with disabilities often end up in Medicaid because it is the only place they can turn to to receive the array of services and supports that they need to survive.

Mr. DEAL. Mr. Page, your time has expired. Would you summarize for us, please, sir?

Mr. PAGE. Certainly. I am—I didn't realize time was slipping away that quick.

Summarize. I guess overall, what I would like to say is we have—I am encouraged by the fact that Dr. McClellan was here, and was talking about different options on ways to implement avenues that will affect people with disabilities, his Money Follows the Person, we are all behind that, in reference to that, there is also the Family Opportunity Act, which he—was mentioned by some of the other members.

And MiCASSA was mentioned by Mr. Shimkus. All these are legislative avenues that can work to increase home and community-based services. They have also all been before this committee for a number of years, and it is a matter of a little bit of political will, also. And what the disability community has found is that we are willing to come here and work with you to get this job done, as a matter of urgency and a point of time, which is now, because if it is not done today, when is it going to be done, and if it is not you, who will it be? Thank you.

[The prepared statement of Lee Page follows:]

PREPARED STATEMENT OF LEE PAGE, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman, members of the Committee, my name is Lee Page. I am an Associate Advocacy Director for the Paralyzed Veterans of America (PVA). PVA is a non-profit national Veterans Service Organization chartered by the Congress of the United States and dedicated to meeting the needs of its members—veterans of military service who are paralyzed as a result of spinal cord injury or disease. While almost all PVA members rely on the Department of Veterans Affairs for health care and support services, potential changes to the VA system may have ramifications for other federal programs such as Medicaid. I also serve as a Co-Chair of the Long-Term Services and Supports Task Force of the Consortium for Citizens with Disabilities (CCD), a Washington-based coalition of more than 100 national disability consumer, provider, and advocacy organizations. I work very closely with a range of national consumer-led disability organizations. As the Congress considers a range of policy options with regard to restructuring of Medicaid long-term services, I am here to offer a perspective from people with disabilities. I will focus my comments on issues affecting non-elderly people with disabilities. For non-veteran people with disabilities, Medicaid is perhaps the most critical program essential to their well-being. Let me also add the observation that cuts of the magnitude contemplated in the budget resolution will preclude any positive reforms that will be meaningful to the many people with disabilities who rely on Medicaid.

The first point that I would like to make is that more must be done to improve and expand access to community-based long-term services and supports. Currently, Medicaid has a spending bias based on a 1965 medical model that refers 70% of funding towards institutional settings and allows only 30% for community and home based long term supports and services.¹ At the dawn of the 21st century and 15 years after the passage of the Americans with Disabilities Act (ADA), people with disabilities are being integrated into all aspects of society. And yet, for the many people with disabilities that rely on Medicaid services, policies are being implemented or contemplated that will drive them back into isolation.

I believe that real and lasting progress in this regard will be made only if Congress protects the fundamental structure of the program that has enabled Medicaid to be a source of progress for the past four decades. Critical features of Medicaid that must be protected include an enforceable individual entitlement to coverage; the strong federal-state partnership, in which the federal government guarantees that it will matches state spending, no matter how many people the program serves or how costly the critical Medicaid services that are provided; and critical consumer protections that ensure that, with limited exceptions, all Medicaid beneficiaries have a right to be treated equally and have a right to receive Medicaid covered services when they are medically necessary.

Recently, HHS Secretary Leavitt has made statements that he believes that states should be given greater “flexibility” with regard to Medicaid’s so-called op-

tional populations and optional services.² From the disability community's perspective, this so-called flexibility is more appropriately characterized as discrimination. The flexibility that is proposed would permit states to make arbitrary distinctions between Medicaid beneficiaries on the basis of whether they fall into mandatory or optional categories. This has nothing whatsoever to do with the level of disability, the need for services, or any factor that could justify disparate treatment. Furthermore, this so-called flexibility would permit states to ignore current Medicaid rules that ensure that services are delivered fairly—such as the requirement that benefits must be comparable across beneficiary groups. Since Medicaid services are provided only when they have been prescribed by qualified health professionals, this so-called flexibility could only lead to some Medicaid services being denied to people who need them. It is important to note that a significant proportion of people with disabilities qualify for Medicaid through optional eligibility categories. Further, the majority of Medicaid spending on people with disabilities is on optional services.³ Optional services are mainly disability focused. What may be considered optional by states and Medicaid administrators in some cases may be essential to a person's efforts to remain independent and fully participate in the mainstream of society.

For Medicaid beneficiaries with disabilities, optional services are not optional. A 35 year old man with schizophrenia may have to take three prescriptions daily to avoid recurrence of symptoms that would place him in an institution. A 25 year old woman with cerebral palsy needs her wheelchair to continue to work part time. A 30 year old man who sustained a spinal cord injury resulting in quadriplegia needs attendant care in bathing, getting dressed, eating and transferring in order to go back to school.

I would like to turn to the important role of Medicaid in providing long-term services and supports to people with disabilities. In addition to Medicaid's role in providing a range of acute care services to people with disabilities, many people with serious and long-lasting disabilities end up on Medicaid because they require long-term services and supports. Medicaid is the largest source of funding for long-term care. The private insurance market generally does not provide long-term services, and Medicare's coverage for long-term services is very limited. People with disabilities often end up on Medicaid because it is the only place that they can turn to receive the array of services and supports that they need to survive. For people who are less familiar with these issues, long-term services and supports are generally non-medical services that provide assistance with core activities of everyday life such as eating and preparing meals, dressing and toileting, and managing a home or personal finances. These services are a critical part of the Medicaid program and were defined in the program's statutory purpose: "and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care..."

I know that some proponents have advocated for a greater reliance on private long-term care insurance as a policy response to growing Medicaid costs for long-term care. I am skeptical that, without fundamental restructuring and greater regulation of the long-term care market, private long-term care insurance can ever develop into a viable tool for retirement planning or for helping individuals and families to plan for long-term care needs later in life. However, it is clear that private long-term care insurance is not a policy solution for financing the long-term care needs of non-elderly people with disabilities. These policies were not developed for children, young adults and younger working people—and in the current market, such coverage would be unavailable or unaffordable to people with disabilities.

While Medicaid plays an essential role in providing long-term services, this is also an area where the program must do better. People with disabilities are looking to the Congress to urgently address barriers that prevent millions of Medicaid beneficiaries with disabilities from receiving community-based long-term services. Medicaid law requires states to provide nursing home care, without requiring states to provide the same level and types of services in the community. This is the "institutional bias." Hundreds of thousands of people with disabilities would like to and could live in their own home and community, if they received long-term services and supports that enable them to do so. According to CMS' Minimum Data Set—Nationally, there are 1,404,406 persons (by definition they are disabled) residing in nursing homes of whom 19.5% (273,859 disabled persons) have stated they want to live in the community. But these individuals are forced to be segregated in an institution as their only option for receiving this assistance.

Virtually all policy makers agree with the disability community that we need to rebalance the Medicaid long-term care system so that all Medicaid beneficiaries have the option of receiving long-term services in their homes and communities. This issue was given momentum five years ago when the United States Supreme Court held in its *Olmstead*⁴ decision that the unjustified institutional isolation of

people with disabilities is discriminatory and unlawful under the Americans with Disabilities Act. While this decision has enormous implications for Medicaid, it did not change the Medicaid law or require an end to the institutional bias. The disability community's preferred solution is for the Congress to swiftly enact the Medicaid Community Attendant Services and Supports Act (MiCASSA), H.R. 910 and S. 401 and HR 910. This legislation would mandate that states offer home and community based services for those individuals with disabilities who are in or are eligible for institutional settings. Some policy makers have misgivings with the MiCASSA model out of concern for the potential cost. While we believe that the only meaningful solution to the challenge of providing expanded access to community-based services will require new resources, the disability community is also supportive of several other initiatives that would make incremental progress toward enacting achieving MiCASSA's goals.

This includes strongly supporting the Money Follows the Person Act, S. 528, an important first step that would provide competitive demonstration projects to enable Medicaid-eligible individuals to receive long-term services in the setting of their choice. States would receive expanded funding for one year for each person that a state moves out of a nursing home or other institution into the community with appropriate services. We have worked closely with Dr. McClellan and the Bush Administration on this initiative which is a central element of the President's New Freedom Initiative of 2001. However, after 5 years, the Bush administration has failed to put forth comprehensive legislation addressing the goals of the New Freedom Initiative, including any proposal to assist states' compliance with the Supreme Court's *Olmstead* decision.

Please note we also support companion legislation, the Family Opportunity Act, that would provide states with the option to provide critical support for families with children with serious disabilities. At the end of the 108th Congress, this Committee linked the two pieces of legislation (FOA and Money Follows the Person) in hopes of moving them together for passage. Unfortunately, that did not happen. We had hoped that the legislation would be introduced as a package in the 109th Congress, sending a strong message that Congress and the Administration are ready to move this issue. Unfortunately, this has not yet happened.

Additionally, we believe there are other incremental steps that the Congress can take to expand access to community-based long-term services. Twenty-nine states provide community long-term services through use of the personal care option and 44 states rely on the rehabilitation services option. These are critical optional services that states have relied upon to develop innovative models for providing community-based long-term services.⁵ We believe that the federal government could assist states in rebalancing their long-term care programs through providing an enhanced match for personal care and rehabilitation services. These approaches could be phased in over time.

It is seductive to think that easy solutions are out there for improving Medicaid. Some claim that reverse mortgages are a policy innovation that will assist Medicaid beneficiaries in financing the cost of long-term services and supports—in a way that lowers federal costs. Similarly, several Members of Congress and the Bush Administration have proposed new restrictions on the transfer of assets before individuals qualify for Medicaid coverage. Easy solutions do not exist and the potential benefits of reverse mortgages or asset transfer restrictions are being oversold. More importantly, however, these policies are largely irrelevant to non-elderly people with disabilities. Non-elderly people with disabilities have lower incomes and fewer resources than many seniors. Many people with disabilities have not had the opportunity to accumulate assets. They have not built up significant equity in their homes with which to take a reverse mortgage and that assumes they can afford to own a home. Moreover, as with other non-elderly individuals, policy makers should be encouraging people with disabilities to accumulate assets for use in their later years, making reverse mortgages particularly inappropriate for these individuals.

In conclusion, as has happened several times in the past, Medicaid is at a critical juncture. The actions of this Congress will determine whether or not Medicaid continues to evolve and adapt to improve the lives of people with disabilities and other Medicaid beneficiaries. It is hard to imagine, however, how positive progress can be made if the Congress enacts large Medicaid cuts—such as the \$10 billion in savings that are being contemplated per the budget resolution. Our perspective is that Medicaid is an effective model of a flexible, adaptable, and working public program that should be expanded and not cut. By protecting the core features of Medicaid, it will continue to serve as a mechanism for achieving an important national goal—and necessity—to assist people with disabilities to live full and meaningful lives, integrated fully in their communities. I urge Congress to look beyond the short-term

budget debate and enact forward-looking policies that people with disabilities and all Americans can applaud.

Mr. DEAL. Thank you. Ms. Allen.

STATEMENT OF KATHRYN G. ALLEN

Ms. ALLEN. Mr. Chairman, Mr. Brown, and members of the subcommittee, thank you for inviting me to be part of this very important hearing today.

Earlier this year, GAO issued a report to coincide with the convening of this Congress, a report entitled “21st Century Challenges: Reexamining the Base of the Federal Government.” That report provides a very comprehensive compendium of areas throughout government that may warrant reconsideration in today’s fiscal climate. One question posed in that report, and which is very germane to today’s hearing, is the question, what options are there for rethinking the Federal, State, and private insurance roles in financing long-term care?

In general, the aging of this baby boom generation, of which I am a member, will lead to a very sharp growth in Federal entitlement spending that, without meaningful reforms, will represent an unsustainable burden on future generations. If you look at the chart that we have displayed, we see that Federal spending for three major entitlement programs which serve persons needing long-term care, Medicaid, Medicare, and Social Security, will nearly double as a share of the economy by the year 2035, and will triple by the year 2080. This represents a growth from 8.5 percent of GDP to about 25 percent just for these three programs. And Federal spending for Medicaid alone, exclusive of State spending, could increase to as much as 5 percent. Now, recently, much attention has been focused on the need for Social Security and Medicare reform, in order to maintain their viability and ability to meet future commitments, but a broader focus would also look at Medicaid. As we have heard today already, about two-thirds of the entire Medicaid program is dedicated to services for persons who are aged and disabled, although they represent only one-fourth of the beneficiaries.

Medicaid also accounts for one of the largest components of most States’ budgets. As we can see in the next graphic, it is a pie chart, that two thirds of all spending now for long-term care, regardless of the age of the beneficiary, is paid for by the public sector. Medicaid alone accounts for almost half of this care, about 48 percent. I would note, though, that this chart differs from the one that Dr. Holtz-Eakin presented, because we did not factor in the cost of informal or donated care.

In coming decades, the sheer number of aging baby boomers is going to swell the numbers of elderly with disabilities and the need for long-term care. We have heard about this already, but this new demand is going to exacerbate the problems we already see. The problems we see today include an inability to obtain the care that is needed at home or in the community, and we see long-term care costs that could be financially catastrophic for families. We see the continuing geographic dispersion of families, which reduces the number of informal, unpaid family caregivers who help elderly persons stay in their homes and live independently as long as possible.

And considering the options and the hard choices that we need to confront for long-term care financing, we have to keep in mind that long-term care is not just about healthcare. It comprises a variety of services that persons who are aged or disabled need beyond medical care to maintain their quality of life. These additional services include housing, transportation, nutrition, and social support to help them continue to live independently. With this in mind, there are several issues that I would like to put on the table that people need to consider in exploring long-term care financing alternatives.

I am going to highlight just three, and there are others in my written statement. The first consideration is determining societal versus personal responsibilities. A fundamental question we need to address is how much the choices of how long-term care needs are met should depend on an individual's own resources, or the extent to which society should supplement those resources to broaden their range of choices. Now, this is particularly true for persons with severe disabilities, who have a limited capacity to produce income. A related question is the extent to which societal responsibility includes providing a minimum safety net, or some form of social insurance, that is consistent for all individuals in similar circumstances regardless of where they live within a State or across the country.

A second consideration is personal preparedness. The public sector has a very important role in this regard, including educating people about the current division between personal and societal responsibilities. Only if the limits of public support are clear will individuals be likely to take steps needed to prepare for any possible disability. Currently, one of the factors contributing to the lack of preparation for long-term care is a widespread misunderstanding about what services Medicare or their own private health insurance will cover. Another public role may be to encourage the availability of sound private long-term care insurance policies. We are hopeful that the Federal Government's own experience in offering long-term care insurance, began just two or 3 years ago, will be instructive in this regard.

Mr. Chairman, the last consideration that I will mention concerns the need to recognize the benefits, the burdens, and the cost of informal care giving. As you well know, as you have pointed out today, family members and other informal caregivers play a critical role in supplying the needs of these individuals. Effective policy may address incentives and supports that enable informal caregivers and family members to continue providing assistance, while taking care to also avoid creating incentives that would supplant that informal care with paid or public services. And as already mentioned today, it is also important to note the physical, emotional, and social burdens that providing care imposes on the caregiver, and its economic cost to the caregiver and society.

Mr. Chairman, these and other considerations will require some very difficult policy choices, and the GAO stands ready to support you and the rest of the Congress in looking at the facts, and analyzing the facts, to help make those choices. Thank you.

[The prepared statement of Kathryn G. Allen follows:]

PREPARED STATEMENT OF KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE—MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss the anticipated growing demand and associated costs for long-term care services, which will be driven largely by the aging baby boom generation, and the challenges that increased demand will bring for federal and state budgets. Earlier this year, we issued a report entitled *21st Century Challenges: Reexamining the Base of the Federal Government* to provide policymakers with a comprehensive compendium of those areas throughout government that could be considered ripe for re-examination and review based on our past work and institutional knowledge.¹ In that report, we presented illustrative questions for policymakers to consider as they carry out their responsibilities. These questions examined major areas of the budget and federal operations including discretionary and mandatory spending, and tax policies and programs. One prominent question that we raised in that report and that will be the focus of my comments today is “What options are there for rethinking the federal, state, and private insurance roles in financing long-term care?”

In general, the aging of the baby boom generation will lead to a sharp growth in federal entitlement spending that, absent meaningful reforms, will represent an unsustainable burden on future generations. As the estimated 76 million baby boomers born between 1946 and 1964 become elderly, Medicare, Medicaid, and Social Security will nearly double as a share of the economy by 2035. We have been able to sustain these entitlements in the past with low depression-era birth rates and a large postwar workforce. However, absent substantive reform of entitlement programs, a rapid escalation of federal spending for Social Security, Medicare, and Medicaid is virtually certain to overwhelm the rest of the federal budget.

Most attention has been focused on the need for Social Security and Medicare reform in order to maintain their viability and ability to meet programmatic commitments. By 2017, Social Security’s cash income (tax revenue) is projected to fall below program expenses. At that time, Social Security will join Medicare’s Hospital Insurance Trust Fund, whose outlays exceeded cash revenues in 2004, as having a cash flow deficit. While these are important issues, a broader focus should also include Medicaid, particularly as it involves financing long-term care. Long-term care includes an array of health, personal care, and supportive services provided to persons with physical or mental disabilities. It relies heavily on financing by public payers, especially Medicaid, and has significant implications for state budgets as well as the federal budget.

My remarks today will focus on (1) the pressure that entitlement spending for Medicare, Medicaid, and Social Security is expected to exert on the federal budget in coming decades; (2) how the aging of the baby boomers will increase the demand for long-term care services; and (3) how these trends will affect the current and future financing of long-term care services, particularly in federal and state budgets. I will also highlight several considerations for any possible reforms of long-term care financing. My comments are based on prior GAO work, particularly a 2002 testimony by the Comptroller General.² We updated prior GAO work by including more recent data from GAO’s budget simulation model, the Centers for Medicare & Medicaid Services, and the U.S. Census Bureau as well as the literature. We conducted our work to update this earlier testimony from February through April 2005 in accordance with generally accepted government auditing standards.

In summary, it is clear that, taken together, Medicare, Medicaid, and Social Security represent an unsustainable burden on future generations. Increased demand for long-term care, which will be driven in part by the aging baby boom generation, will contribute further to federal and state budget burdens. Estimates suggest the number of disabled elderly who cannot perform basic activities of daily living without assistance may as much as double from 2000 through 2040. Current problems with the provision and financing of long-term care could be exacerbated by the swelling numbers of the baby-boom generation needing care. These problems include whether individuals with disabilities receive adequate services, the potential for families to face financially catastrophic long-term care costs, and the burdens and social costs that heavy reliance on unpaid care from family members and other informal caregivers create coupled with possibly fewer caregivers available in coming generations. Long-term care spending from all public and private sources, which was about \$183

¹GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO05325SP (Washington, D.C.: February 2005).

²GAO, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO02544T (Washington, D.C.: March 21, 2002).

billion for persons of all ages in 2003, will increase dramatically in the coming decades as the baby boom generation ages. Spending on long-term care services just for the elderly is estimated to increase from 2000 by more than two-and-a-half times by 2040 and could nearly quadruple in constant dollars to \$379 billion by 2050, according to some estimates. Without fundamental financing changes, Medicaid—which pays over one-third of long-term care expenditures for the elderly—can be expected to remain one of the largest funding sources, straining both federal and state governments.

In considering options for reforming long-term care financing in light of these anticipated demands for assistance and budgeting stresses, it is important to keep in mind that long-term care is not just about health care. It also comprises a variety of services an aged and/or disabled person requires to maintain quality of life—including housing, transportation, nutrition, and social support to help maintain independent living. Given the challenges in providing and paying for these myriad and growing needs, several considerations for shaping reform proposals include:

- determining societal responsibilities;
- considering the potential role of social insurance in financing;
- encouraging personal preparedness;
- recognizing the benefits, burdens, and costs of informal caregiving;
- assessing the balance of state and federal responsibilities to ensure adequate and equitable satisfaction of needs;
- adopting effective and efficient implementation and administration of reforms; and
- developing financially sustainable public commitments.

BACKGROUND

Long-term care includes many types of services needed when a person has a physical or mental disability. Individuals needing long-term care have varying degrees of difficulty in performing some activities of daily living without assistance, such as bathing, dressing, toileting, eating, and moving from one location to another. They may also have trouble with instrumental activities of daily living, which include such tasks as preparing food, housekeeping, and handling finances. They may have a mental impairment, such as Alzheimer's disease, that necessitates assistance with tasks such as taking medications or supervision to avoid harming themselves or others. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disability will develop or worsen.

According to the 1999 National Long-Term Care Survey, approximately 7 million elderly had some sort of disability in 1999, including about 1 million needing assistance with at least five activities of daily living.³ Assistance takes place in many forms and settings, including institutional care in nursing homes or assisted living facilities, and home care services. Further, many disabled individuals rely exclusively on unpaid care from family members or other informal caregivers.

Nationally, spending from all public and private sources for long-term care for all ages totaled about \$183 billion in 2003, accounting for about 13 percent of all health care expenditures.⁴ About 69 percent of expenditures for long-term care services were paid for by public programs, primarily Medicaid and Medicare. Individuals financed about 20 percent of these expenditures out of pocket and, less often, private insurers paid for long-term care. Moreover, these expenditures did not include the extensive reliance on unpaid long-term care provided by family members and other informal caregivers. Figure 1 shows the major sources financing these expenditures.

Medicaid, the joint federal-state health-financing program for low-income individuals, continues to be the largest funding source for long-term care. Medicaid provides coverage for poor persons and for many individuals who have become nearly impoverished by “spending down” their assets to cover the high costs of their long-term care. For example, many elderly persons become eligible for Medicaid as a result of depleting their assets to pay for nursing home care that Medicare does not cover. In 2003, Medicaid paid 48 percent (about \$87 billion) of total long-term care expenditures. States share responsibility with the federal government for Medicaid, paying on average approximately 43 percent of total Medicaid costs in fiscal year

³See Kenneth G. Manton and XiLiang Gu, “Changes in the Prevalence of Chronic Disability in the United States Black and NonBlack Population Above Age 65 from 1982 to 1999,” *Proceedings of the National Academy of Sciences of the United States of America*, vol. 98, no. 11, (2001). The National Long-Term Care Survey was conducted in 1982, 1984, 1989, 1994, 1999, and 2004, but the 2004 results are not yet available.

⁴Based on our analysis of data from the Office of the Actuary of the Centers for Medicare & Medicaid Services and The MEDSTAT Group. These figures include long-term care for all people, regardless of age.

2002.⁵ Eligibility for Medicaid-covered long-term care services varies widely among states. Spending also varies across states—for example, in fiscal year 2000, Medicaid per capita long-term care expenditures ranged from \$73 per year in Nevada to \$680 per year in New York. For the national average, about 57 percent of Medicaid long-term care spending in 2002 was for the elderly. In 2003, nursing home expenditures dominated Medicaid long-term care expenditures, accounting for about 47 percent of its long-term care spending. Home care expenditures make up a growing share of Medicaid long-term care spending as many states use the flexibility available within the Medicaid program to provide long-term care services in home- and community-based settings.⁶ From 2000 through 2003, home and personal care expenditures grew at an average annual rate of 15.9 percent compared with 4.0 percent for nursing facility spending. Expenditures for Medicaid home- and community-based services for long-term care almost doubled from 1998 to 2003—from about \$10 billion to about \$19 billion.

Other significant long-term care financing sources include:

- Individuals' out-of-pocket payments, the second largest source of long-term care expenditures, accounted for 20 percent (about \$38 billion) of total expenditures in 2003. The vast majority (82 percent) of these payments were used for nursing home care.
- Medicare spending accounted for 18 percent (about \$33 billion) of total long-term care expenditures in 2003. While Medicare primarily covers acute care, it also pays for limited stays in post-acute skilled nursing care facilities and home health care.
- Private insurance, which includes both traditional health insurance and long-term care insurance,⁷ accounted for 9 percent (about \$16 billion) of long-term care expenditures in 2003.

ABSENT REFORM, SPENDING FOR MEDICAID, MEDICARE, AND SOCIAL SECURITY WILL PUT UNSUSTAINABLE PRESSURE ON THE FEDERAL BUDGET

Before focusing on the increased burden that long-term care will place on federal and state budgets, it is important to look at the broader budgetary context. As we look ahead we face an unprecedented demographic challenge with the aging of the baby boom generation. As the share of the population 65 and over climbs, federal spending on the elderly will absorb a larger and ultimately unsustainable share of the federal budget and economic resources. Federal spending for Medicaid, Medicare, and Social Security is expected to surge—nearly doubling by 2035—as people live longer and spend more time in retirement. In addition, advances in medical technology are likely to keep pushing up the cost of health care. Moreover, the baby boomers will be followed by relatively fewer workers to support them in retirement, prompting a relatively smaller employment base from which to finance these higher costs. Based on CBO's long-term Medicaid estimates, the federal share of Medicaid as a percent of GDP will grow from today's 1.5 percent to 2.6 percent in 2035 and reach 4.8 percent in 2080. Under the 2005 Medicare trustees' intermediate estimates, Medicare will almost triple as a share of gross domestic product (GDP) between now and 2035 (from 2.7 percent to 7.5 percent) and reach 13.8 percent of GDP in 2080. Under the Social Security trustees' intermediate estimates, Social Security spending will grow as a share of GDP from 4.3 percent today to 6.3 percent in 2035, reaching 6.4 percent in 2080. (See fig. 2.) Combined, in 2080 almost one-quarter of GDP will be devoted to federal spending for these three programs alone.

To move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government. Our long-term budget simulations serve to illustrate the increasing constraints on federal budgetary flexibility that will be driven by entitlement spending growth. Assume, for example, that all expiring tax provisions are extended, revenue remains constant

⁵The federal share of Medicaid funding varies by state and is based on a state's per capita income in relation to the national per capita income. By statute, the federal share of Medicaid expenditures across individual states may range from 50 to 83 percent. 42 U.S.C. § 1396 d (b) (2000).

⁶Through Medicaid home- and community-based services, states cover a wide variety of non-medical and social services and supports that allow people to remain in the community. These services include personal care, personal call devices, homemakers' assistance, chore assistance, adult day health care, and other services that are demonstrated as cost-effective and necessary to avoid institutionalization. In their home- and community-based services programs, however, states often limit eligibility or the scope of services in order to control costs.

⁷Private long-term care insurance commonly includes policies that provide coverage for at least 12 months of necessary services—as demonstrated by an inability to perform a certain number of activities of daily living—provided in settings other than acute-care hospital units.

thereafter as a share of GDP, and discretionary spending keeps pace with the economy. Under these conditions, by 2040 federal revenues may be adequate to pay little more than interest on the federal debt.⁸ (See fig. 3.)

Beginning about 2010, the share of the population that is age 65 or older will begin to climb, with profound implications for our society, our economy, and the financial condition of these entitlement programs. In particular, both Social Security and the Hospital Insurance portion of Medicare are largely financed as pay-as-you-go systems in which current workers' payroll taxes pay current retirees' benefits. Therefore, these programs are directly affected by the relative size of populations of covered workers and beneficiaries. Historically, this relationship has been favorable. In the near future, however, the overall worker-to-retiree ratio will change in ways that threaten the financial solvency and sustainability of these entitlement programs. In 2000, there were 4.8 working-age persons (20 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.9.⁹ This decline in the overall worker-to-retiree ratio will be due to both the surge in retirees brought about by the aging baby boom generation as well as falling fertility rates, which translate into relatively fewer workers in the near future.

Social Security's projected cost increases are due predominantly to the burgeoning retiree population. Even with the increase in the Social Security eligibility age to 67, these entitlement costs are anticipated to increase dramatically in the coming decades as a larger share of the population becomes eligible for Social Security, and if, as expected, average longevity increases.

As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Medicare growth rates reflect not only a rapidly increasing beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. While advances in science and technology have greatly expanded the capabilities of medical science, disproportionate increases in the use of health services have been fueled by the lack of effective means to channel patients into consuming, and providers into offering, only appropriate services. In fiscal year 2004, Medicare spending grew by 8.5 percent and is up 9.9 percent for the first 6 months of fiscal year 2005.¹⁰ The implementation of the Medicare outpatient drug benefit in January 2006 will further increase Medicare spending in future years.

To obtain a more complete picture of the future health care entitlement burden, especially as it relates to long-term care, we must also acknowledge and discuss the important role of Medicaid. In 2003, approximately 69 percent of all Medicaid dollars was dedicated to services for the elderly and people with disabilities. Medicaid is the second largest and fastest growing item in overall state spending. At the February 2005 National Governors Association meeting, governors reported that states are faced with proposing cuts in their Medicaid programs. Over the longer term, the increase in the number of elderly will add considerably to the strain on federal and state budgets as governments struggle to finance increased Medicaid spending. In addition, this strain on state Medicaid budgets may be exacerbated by fluctuations in the business cycle. State revenues decline during economic downturns, while the needs of the disabled for assistance remain constant.

BABY BOOM GENERATION WILL GREATLY EXPAND DEMAND FOR LONG-TERM CARE

In coming decades, the sheer number of aging baby boomers will swell the number of elderly with disabilities and the need for services. These overwhelming numbers offset the slight reductions in the prevalence of disability among the elderly reported in recent years. In 2000, individuals aged 65 or older numbered 35.1 million people—12.4 percent of our nation's total population. By 2020, that percentage will increase by nearly one-third to 16.3 percent—one in six Americans—and will represent nearly 20 million more elderly than there were in 2000. By 2040, the number of elderly aged 85 years and older—the age group most likely to need long-term care services—is projected to increase more than 250 percent from 4.3 million in 2000 to 15.4 million (see fig. 4).

⁸For additional discussion of our budget simulations, see GAO, *Our Nation's Fiscal Outlook: The Federal Government's Long-Term Budget Imbalance*, at <http://www.gao.gov/special.pubs/longterm/longterm.html>.

⁹The specific ratios for the programs differ because of differences in the respective covered populations. Specifically, for Social Security, the ratio of covered workers to beneficiaries in 2005 is estimated to be 3.3. Under the 2005 Trustees' intermediate estimates, this ratio is projected to decline to 2.1 by 2035. For Medicare Hospital Insurance, the ratio was estimated to be 3.9 for 2005 and was projected to decline to 2.3 by 2035 under the 2005 Trustees' intermediate estimates.

¹⁰See CBO, *Monthly Budget Review* for November 4, 2004, and April 6, 2005.

It is difficult to precisely predict the future increase in the number of the elderly with disabilities, given the counterbalancing trends of an increase in the total number of elderly and a possible continued decrease in the prevalence of disability. The number of elderly with disabilities remained fairly constant from 1982 through 1999 while the percentage of those with disabilities fell between 1 and 2 percent a year from 1984 through 1999. Possible factors contributing to this decreased prevalence of disability include improved health care, improved socioeconomic status, and better health behaviors. The positive benefits of the decreased prevalence of disability, however, will be overwhelmed by the sheer numbers of aged baby boomers. The total number of disabled elderly is projected to increase, with estimates varying from an increase of one-third to twice the current level, or as high as 12.1 million by 2040.

The increased number of disabled elderly will exacerbate current problems in the provision and financing of long-term care services. For example, in 2000 it was reported that approximately one in five adults with long-term care needs and living in the community reported an inability to receive needed care, such as assistance in toileting or eating, often with adverse consequences.¹¹ In addition, disabled elderly may lack family support or the financial means to purchase medical services. Long-term care costs can be financially catastrophic for families. Services, such as nursing home care, are very expensive; while costs can vary widely, a year in a nursing home typically costs more than \$50,000, and in some locations can be considerably more. Because of financial constraints, many elderly rely heavily on unpaid caregivers, usually family members and friends; overall, the majority of care received in the community is unpaid. However, in coming decades, fewer elderly may have the option of unpaid care because a smaller proportion may have a spouse, adult child, or sibling to provide it. By 2020, the number of elderly who will be living alone with no living children or siblings is estimated to reach 1.2 million, almost twice the number without family support in 1990.¹² In addition, geographic dispersion of families may further reduce the number of unpaid caregivers available to elderly baby boomers.

SPENDING FOR LONG-TERM CARE FOR ELDERLY ANTICIPATED TO INCREASE SHARPLY

Public and private spending on long-term care was about \$183 billion for persons of all ages in 2003. CBO projected in 1999 that long-term care spending for the elderly could increase by more than two-and-a-half times from 2000 to 2040. A 2001 study projected that these expenditures could quadruple from 2000 through 2050, reaching \$379 billion in 2050.¹³ (See fig. 5.) Estimates of future spending are imprecise, however, due to the uncertain effect of several important factors, including how many elderly will need assistance, the types of care they will use, and the availability of public and private sources of payment for care. Absent significant changes in the availability of public and private payment sources, however, future spending is expected to continue to rely heavily on public payers, particularly Medicaid, which estimates indicate paid about 35 percent of long-term care expenditures for the elderly in 2004.

One factor that will affect spending is how many elderly will need assistance. As noted earlier, even with continued decreases in the prevalence of disability, aging baby boomers are expected to have a disproportionate effect on the demand for long-term care. Another factor influencing projected long-term care spending is the type of care that the baby boom generation will use. Per capita expenditures for nursing home care greatly exceed those for care provided in other settings. Since the 1990s, there have been increases in the use of paid home care as well as in assisted living facilities, a relatively newer and developing type of housing. It is unclear what effect continued growth in paid home care, assisted living facilities, or other care alternatives may have on future expenditures. Any increase in the availability of home care may reduce the average cost per disabled person, but the effect could be offset if there is an increase in the use of paid home care by persons currently not receiving these services.

Changes in the availability of public and private sources to pay for care will also affect expenditures. Private long-term care insurance has been viewed as a possible

¹¹ Judith Feder et al., "Long-Term Care in the United States: An Overview," *Health Affairs*, May/June 2000, pp. 40-56.

¹² "Aging into the 21st Century," prepared by Jacob Siegel for the Administration on Aging, U.S. Department of Health and Human Services, May 1996.

¹³ Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services, who contracted with The Lewin Group, as published in Urban Institute, "Long-Term Care: Consumers, Providers, and Financing, A Chart Book" (Washington, D.C.: March 2001).

means of reducing catastrophic financial risk for the elderly needing long-term care and relieving some of the financial burden currently falling on public long-term care programs. Increases in private insurance may lower public expenditures but raise spending overall because insurance increases individuals' financial resources when they become disabled and allows the purchase of additional services. The number of policies in force remains relatively small despite improvements in policy offerings and the tax deductibility of premiums. However, as we have previously testified, questions about the affordability of long-term care policies and the value of the coverage relative to the premiums charged have posed barriers to more widespread purchase of these policies.¹⁴ Further, many baby boomers continue to assume they will never need such coverage or mistakenly believe that Medicare or their own private health insurance will provide comprehensive coverage for the services they need. If private long-term care insurance is expected to play a larger role in financing future generations' long-term care needs, consumers need to be better informed about the costs of long-term care, the likelihood that they may need these services, and the limits of coverage through public programs and private health insurance.

With or without increases in the availability of private insurance, Medicaid and Medicare are expected to continue to pay for the majority of long-term care services for the elderly in the future. Without fundamental financing changes, Medicaid can be expected to remain one of the largest funding sources for long-term care services for aging baby boomers, with Medicaid expenditures for long-term care for the elderly reaching as high as \$132 billion by 2050. As noted earlier, this increasing burden will strain both federal and state governments.

CONSIDERATIONS FOR REFORMING LONG-TERM CARE FINANCING

Given the anticipated increase in demand for long-term care services resulting from the aging of the baby boom generation, the concerns about the availability of services, and the expected further stress on federal and state budgets and individuals' financial resources, some policymakers and advocates have called for long-term care financing reforms. Indeed, we identified options for rethinking the federal, state, and private insurance roles in financing long-term care as one of the key questions that our nation needs to face as it addresses 21st century challenges.¹⁵ The Comptroller General previously testified in 2002 on several considerations for policymakers to keep in mind when considering reforms for long-term care financing, and these considerations remain relevant today.

At the outset, it is important to recognize that long-term care services are not just another set of traditional health care services. Meeting acute and chronic health care needs is an important element of caring for aging and disabled individuals. Long-term care, however, encompasses services related to maintaining quality of life, preserving individual dignity, and satisfying preferences in lifestyle for someone with a disability severe enough to require the assistance of others in everyday activities. Some long-term care services are akin to other health care services, such as personal assistance with activities of daily living or monitoring or supervision to cope with the effect of dementia. Other aspects of long-term care, such as housing, nutrition, and transportation are services that all of us consume daily but become an integral part of long-term care for a person with a disability. Disabilities can affect housing needs, nutritional needs, or transportation needs. But, what is more important is that where one wants to live or what activities one wants to pursue also affects how needed services can be provided. Providing personal assistance in a congregate setting such as a nursing home or assisted living facility may satisfy more of an individual's needs, be more efficient, and involve more direct supervision to ensure better quality than when caregivers travel to individuals' homes to serve them one on one. Yet, those options may conflict with a person's preference to live at home and maintain autonomy in determining his or her daily activities.

Keeping in mind that policies need to take account of the differences involved in long-term care, there are several issues that policymakers may wish to consider as they address long-term care financing reforms. These include:

- **Determining societal responsibilities.** A fundamental question is how much the choices of how long-term care needs are met should depend upon an individual's own resources or whether society should supplement those resources to broaden the range of choices. For a person without a disability requiring long-

¹⁴ GAO, *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services*, GAO/01/563T (Washington, D.C.: Mar. 27, 2001) and *Long-Term Care Insurance: Better Information Critical to Prospective Purchasers*, GAO/THEHS00196 (Washington, D.C.: Sept. 13, 2000).

¹⁵ GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*.

term care, where to live and what activities to pursue are lifestyle choices based on individual preferences and resources. However, for someone with a disability, those lifestyle choices affect the costs of long-term care services. The individual's own resources—including financial resources and the availability of family or other informal supports—may not be sufficient to preserve some of their choices and also obtain needed long-term care services.

Societal responsibilities may include maintaining a safety net to meet individual needs for assistance. However, the safety net may not provide a full range of choices in how those needs are met. Persons who require assistance multiple times a day and lack family members to provide some share of this assistance may not be able to have their needs met in their own homes. The costs of meeting such extensive needs may mean that sufficient public support is available only in settings such as assisted living facilities or nursing homes. More extensive public support may be extended, but decisions to do so should carefully consider affordability in the context of competing demands for our nation's resources.

- **Considering the potential role of social insurance in financing.** Government's role in many situations has extended beyond providing a safety net. Sometimes this extended government role has been a result of efficiencies in having government undertake a function, or in other cases this role has been a policy choice. Some proposals have recommended either voluntary or mandatory social insurance to provide long-term care assistance to broad groups of beneficiaries. In evaluating such proposals, careful attention needs to be paid to the limitations and conditions under which services will be provided. In addition, who will be eligible and how such a program will be financed are critical choices. As in establishing a safety net, it is imperative that any option under consideration be thoroughly assessed for its affordability over the longer term.
- **Encouraging personal preparedness.** Becoming disabled is a risk. Not everyone will experience disability during his or her lifetime and even fewer persons will experience a severe disability requiring extensive assistance. This is the classic situation in which having insurance to provide additional resources to deal with a possible disability may be better than relying on personally saving for an event that may never occur. Insurance allows both persons who eventually will become disabled and those who will not to use more of their economic resources during their lifetime and to avoid having to put those resources aside for the possibility that they may become disabled.

The public sector has at least two important potential roles in encouraging personal preparedness. One is to adequately educate people about the current divisions between personal and societal responsibilities. Only if the limits of public support are clear will individuals be likely to take steps to prepare for a possible disability. Currently, one of the factors contributing to the lack of preparation for long-term care among the elderly is a widespread misunderstanding about what services Medicare will cover. Another public sector role may be to assure the availability of sound private long-term care insurance policies and possibly to create incentives for their purchase. Progress has been made in improving the value of insurance policies through state insurance regulation and through strengthening the requirements for policies qualifying for favorable tax treatment enacted by the Health Insurance Portability and Accountability Act of 1996.¹⁶ Furthermore, since 2002 the federal government has offered long-term care insurance to federal employees, military personnel, retirees, and their families, providing the largest offering of long-term care insurance. While the federal government's program is still very new, other employers and policymakers will likely be carefully watching the federal government's experience in offering long-term care insurance. Long-term care insurance remains an evolving product, and given the flux in how long-term care services are delivered, it is important to monitor whether long-term care insurance regulations need adjustments to ensure that consumers receive fair value for their premium dollars.

- Recognizing the benefits, burdens, and costs of informal caregiving. Family and other informal caregivers play a critical role in supplying the bulk of long-term care to disabled persons. Effective policy must create incentives and supports for enabling informal caregivers to continue providing assistance. Further, care should be taken to avoid creating incentives that result in informal care being inappropriately supplanted by formal paid services. At the same time, it is important to recognize the physical, emotional, and social burdens that providing care impose on the caregiver and its economic costs to the caregiver and to soci-

¹⁶ Pub. L. No. 104-191, §§321-327, 110 Stat. 1936, 2054-2067.

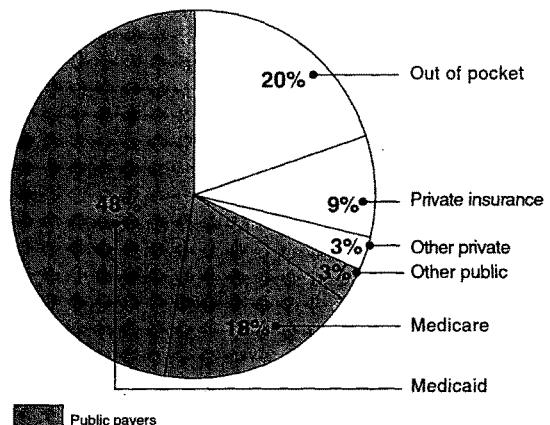
ety. Caregiving may create needs in caregivers themselves that require respite or other relief services. In addition, caregiving can conflict with caregivers' employment, creating economic losses for caregivers and society. Such losses in productivity will become even more important in the coming decades as the proportion of the population that is working-age declines.

- Assessing the balance of federal and state responsibilities to ensure adequate and equitable satisfaction of needs. Reforms in long-term care financing may require reevaluating the traditional federal and state financing roles to better ensure an equitable distribution of public support for individuals with disabilities. The variation across states in Medicaid spending per capita on long-term care is in part reflective of differences among states in generosity of services as well as their fiscal capacity. Given these differences, having states assume primary responsibility for financing long-term care subjects individuals to different levels of support depending on where they live. In addition, because state revenues are sensitive to the business cycle and states generally must have balanced budgets, their services become vulnerable during economic downturns.
- Adopting effective and efficient implementation and administration of reforms. Proposed reforms to better meet the increasing demand for long-term care within budget constraints will be successful only if they are administratively feasible, effectively reach targeted populations and unmet needs, and efficiently provide needed services at minimum cost while complementing already available services and financing sources.
- Developing financially sustainable public commitments. Finally, as noted earlier, absent reform, existing federal entitlement commitments for Medicaid, Medicare, and Social Security will represent an increasing and potentially unsustainable share of the economy. States, too, are concerned about their budgetary commitments for long-term care through their share of the Medicaid program. Before committing to any additional public role in financing long-term care, it is imperative to provide reasonable assurance that revenues will be available to fund its future costs.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

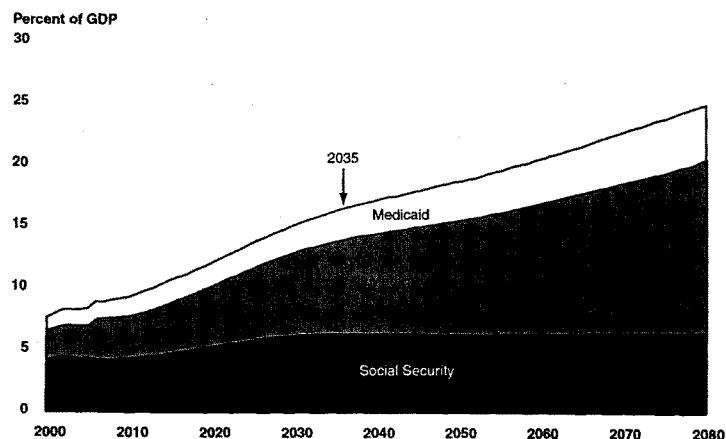
CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Other individuals who made key contributions include John Dicken, Linda F. Baker, Laura Sutton Elsberg, James R. McTigue, and Joseph Petko.

Figure 1: Funding Sources for Long-Term Care, 2003

Source: GAO analysis of 2003 data from the Centers for Medicare & Medicaid Services and The MEDSTAT Group.

Notes: Amounts do not include unpaid care provided by family members or other informal caregivers.
Percentages do not add to 100 percent due to rounding.

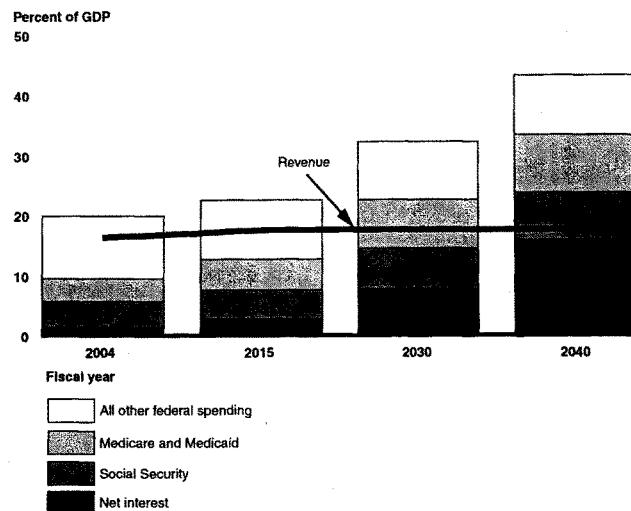
Figure 2: Federal Spending for Medicaid, Medicare, and Social Security as a Percentage of GDP, 2000 through 2080

Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration; Office of the Actuary, Centers for Medicare & Medicaid Services; and the Congressional Budget Office.

Notes: Medicaid spending includes federal, but not state, expenditures.

Social Security and Medicare projections based on the intermediate assumptions of the 2005 Trustees' Reports. Medicaid projections based on the Congressional Budget Office's (CBO) January 2005 short-term Medicaid estimates and the CBO's December 2003 long-term Medicaid projections under midrange assumptions.

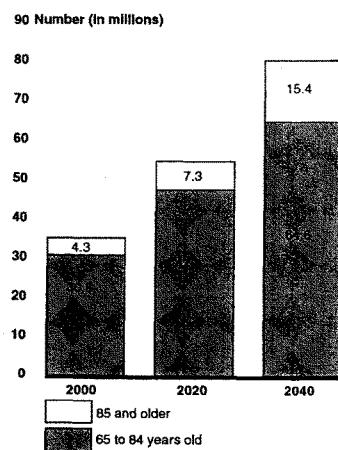
Figure 3: Composition of Federal Spending as a Share of GDP Assuming Discretionary Spending Grows with GDP after 2004 and All Expiring Tax Provisions Are Extended



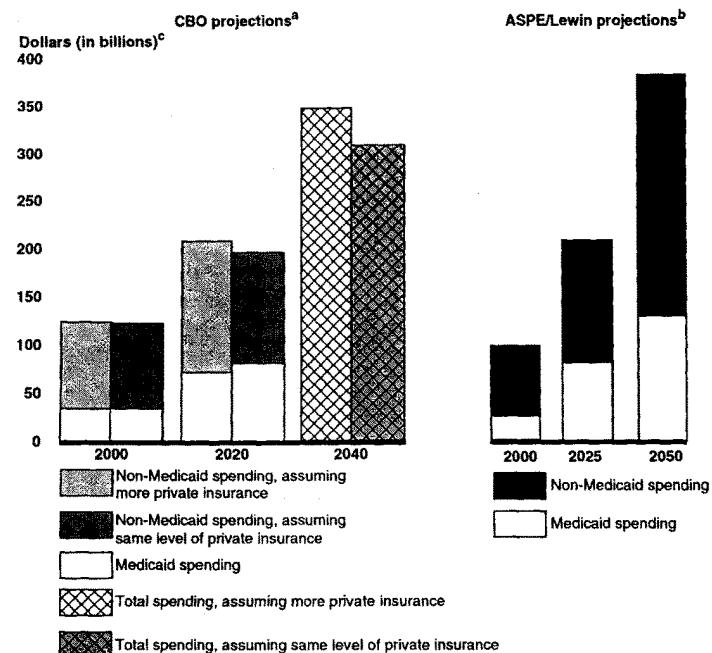
Source: GAO's March 2005 analysis.

Notes: Although the revenue projections assume that expiring tax provisions are extended, federal revenue as a share of GDP increases through 2015 due to (1) taxpayers paying higher marginal tax rates as the economy grows (referred to as "real bracket creep"), (2) more taxpayers becoming subject to the alternative minimum tax, and (3) increased revenue from tax-deferred retirement accounts. After 2015, the analysis assumes that revenue as a share of GDP is held constant. For additional information on our budget simulations, see GAO, *Our Nation's Fiscal Outlook: The Federal Government's Long-Term Budget Imbalance*, at <http://www.gao.gov/special.pubs/longterm/longterm.html>.

Figure 4: Elderly Population, 2000 through 2040



Sources: U.S. Census Bureau, *Annual Estimates of the Population by Sex and Five-Year Age Groups for the United States: April 1, 2000 to July 1, 2003 (NC-EST2003-01)* (June 2004), and *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin* (Mar. 2004).

Figure 5: Long-Term Care Expenditures for the Elderly, 2000 through 2050

Sources: CBO, "Projections of Expenditures for Long-Term Care Services for the Elderly" (Washington, D.C.: March 1999) and ASPE/Lewin, published in Urban Institute, "Long-Term Care: Consumers, Providers, and Financing, A Chart Book" (Washington, D.C.: March 2001), with additional information provided by ASPE on projected Medicaid spending.

^aCBO did not separately report spending by Medicaid or any other financing source as a portion of the total estimated long-term care expenditures for the elderly for years later than 2020.

^bASPE/Lewin did not report separate estimates for different assumptions about the role of private insurance.

^cProjections are in constant dollars.

Mr. DEAL. Thank you. Ms. O'Shaughnessy.

STATEMENT OF CAROL O'SHAUGHNESSY

Ms. O'SHAUGHNESSY. Thank you, Mr. Chairman and Mr. Brown, for the opportunity to testify today. I would like to summarize my written comments, which contain information about the characteristics of the long-term care population, and public and private spending.

The first point I would like to make is that the need for long-term care affects people of all ages, children who are born with disabling conditions, such as mental retardation or cerebral palsy, working age adults with inherited or acquired disabling conditions, and the elderly, who have chronic conditions. About 56 percent of all people receiving care are elderly, and the remainder are people who are younger. But 6 to 8 million persons have significant disabilities. That is, they have at least one limitation in an activity of daily living. There are many more who have other, less serious limitations. The vast majority of adults, regardless of age, over 80 percent, receive care in home and community-based settings.

People enter a nursing home only as a last resort, due to significant disabilities, or they need 24 hour supervision for—due to a cognitive disability, such as Alzheimer's disease, and they have fragile or non-existing family support systems. I would just like to point out that about half of people who are living in the community with long-term care needs have very significant disabilities with three or more limitations in activities of daily living.

As we talked about today, in terms of public and private spending, the amount was \$182 billion in 2003, despite the significant spending, the Nation lacks a comprehensive policy on long-term care. Of total public spending, that is \$123 billion, 68 percent is from public sources, yet most care received by persons with disabilities comes from informal, unpaid supports. Assisting families to prepare for the potentially catastrophic costs of long-term care is viewed by many, as we have heard today, as an important component of family financial security.

Coverage of institutional care, largely under Medicaid, has defined Federal policy for decades. However, in 1999, Supreme Court decision Olmstead has sharpened Federal and State policy attention on home and community-based services. The Court held that institutionalization of persons who could live in community settings violates the Americans with Disabilities Act, and many States are faced with many Olmstead suits in their jurisdictions.

The last time Congress made a systemic change in Federal long-term care policy was in 1981, with the creation of the Medicaid home and community-based waiver program that we have heard a lot about today. The last time Congress comprehensively reviewed long-term care was in 1990, with the Pepper Commission. Despite enormous Federal and—research and demonstration activities to inform Federal policy, Congress has not reached consensus about where to go.

As we have heard today, Medicaid by default is the Nation's primary source of public financing. One-third of all Medicaid funding goes to long-term care. About 67 percent of this was for institutional care, and 33 percent for home and community-based services. I would just like to point out with the 67 percent, we have, of that proportion, we have about \$44 million going to nursing homes, but \$11 billion going to intermediate care facilities for the mentally retarded.

From 1990 to 2003, Medicaid long-term care expenditures grew at an annual rate of about 8 percent, compared to an average rate of growth for all Medicaid spending of 10 percent. Over the last 15 years, Medicaid spending on long-term care has changed in composition, with a greater proportion going to home and community-based services, and a lower proportion for institutions. In 1990, 87 percent of Medicaid spending was on institutional care. In 2003, as I said, it is at 67 percent.

These home and community-based service waiver programs have grown significantly, and States have made financial commitments to them in order to respond to consumer preferences. However, despite this growth, many States have waiting lists for home and community-based services programs, and I would also like to point out that of the \$18 or so billion, \$18 to \$20 billion for the home and community-based waivers, three quarters of that money goes

for persons with mental retardation. About one-third of the recipients, we heard about a million recipients, we can figure that about one third of the recipients for home and community-based services, based on a somewhat smaller number, are aged persons.

For the past two decades, the principle debate in reform has been on the respective roles of the public and private sectors. On the one hand, proposals have been advanced for new social insurance programs, in order to provide individuals a minimum floor protection against the catastrophic costs. Alternatively, we have heard a lot about private sector financing, such as insurance, based on the rationale that the Nation can't afford an additional tax burden. While some policymakers are concerned about new social insurance programs, others are concerned about the affordability of private, long-term care solutions, or insurance by moderate and low income individuals. Because of the diverse socioeconomic and disability characteristics of the population in need, one approach to financing reform may not fit all people. Defining the public and private roles for the diverse groups may need to account for their varying abilities and financial capabilities.

Other subsidiary issues we have heard a lot about today would be how to create more incentives for home and community-based services and assist family caregivers, and encourage individuals and families to prepare for the potentially catastrophic costs. CRS is currently working on a report that would explore many of these options, and we would be glad to talk to you about that later.

Thank you.

[The prepared statement of Carol O'Shaughnessy follows:]

PREPARED STATEMENT OF CAROL O'SHAUGHNESSY,¹ SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE

Good morning, Mr. Chairman and Members of the Committee. My name is Carol O'Shaughnessy. I am a Specialist in Social Legislation at the Congressional Research Service. I am pleased to present testimony this morning. My testimony summarizes key characteristics about people who receive long-term care services, services they receive, and the role of public programs in financing these services.

Summary

Long-term care support refers to a range of health and social services needed by persons who lack the capacity for self-care due to physical, cognitive, or mental illnesses that result in functional impairment and dependence on others for an extended period of time. Long-term care services include care in nursing homes and other institutions, as well as in home and community settings. The need for long-term care is measured by a person's inability to carry out basic human functions, or activities of daily living (ADLs), such as bathing, dressing, eating, toileting, transferring from a bed to a chair, and getting around inside the home.² It is also measured in terms of people needing supervision with performing ADLs when they have cognitive impairments, such as dementia. The extent of care needed varies depending upon a person's degree of impairment.

• *The need for long-term care affects persons of all ages*—children who are born with disabling conditions, such as mental retardation, or cerebral palsy; working age adults with inherited or acquired disabling conditions; and the elderly who have chronic conditions or illnesses. While the likelihood of needing long-term care assistance occurs more frequently in older ages, advances in medical care are enabling persons of all ages with disabilities to live longer. Of all persons receiving assistance

¹ This testimony includes key contributions from Bob Lyke, Specialist in Social Legislation, Diane Justice, Specialist in Gerontology, Laura Shrestha, Specialist in Demography, Specialist in Social Legislation, and Julie Stone and Karen Tritz, Analysts in Social Legislation. Technical support was provided by Barbara Sanders and Charles Dibble, CRS.

² Other measures include a person's need for assistance with meal preparation, and light housework, among other things, known as instrumental activities of daily living (IADLs).

with at least one ADL and who reside at home or in nursing homes, about 56% are persons over age 65, and 44% are under age 65.

- In 2003, total public and private spending on long-term care was \$182 billion. Despite this significant spending, the nation lacks a comprehensive policy on long-term care. While multiple public programs provide assistance, no one program is designed to support the full range of long-term care services and supports.

- Of total public and private spending, \$123 billion, or 68%, is from public sources. Yet, most care received by people with disabilities is provided by unpaid, informal sources—family and friends. The aging of society will exacerbate demand on family caregivers. Assisting families to prepare for potentially catastrophic costs of long-term care is viewed by many as an important component of family financial security.

- Coverage of institutional care, largely under Medicaid, has defined federal long-term care policy for decades. However, a 1999 Supreme Court decision—*Olmstead v. L.C.*—has sharpened federal and state policy attention on home and community-based services. The Court held that, under certain circumstances, institutionalization of persons who could live in community settings, violates the Americans with Disabilities Act (ADA).

- Despite enormous federal research and demonstration activities designed to inform federal long-term care policy over the last several decades, Congress has not reached consensus on what road to take. The complexity of financing and delivering long-term care to diverse groups of persons with disabilities in a variety of settings through multiple federal programs has been a challenge to federal and state governments.

- The last time Congress made a systemic change in federal long-term care policy was in 1981 when it created the Medicaid Section 1915(c) home and community-based services waiver program for persons who would otherwise require care in institutions. The last time Congress comprehensively reviewed policy options for long-term care reform was in 1990 under the U.S. Bipartisan Commission on Comprehensive Health Care (known as the Pepper Commission). Other changes have included changes in Medicaid eligibility rules for long-term care services when, in 1988, Congress provided financial protections for spouses of persons needing nursing home care and other Medicaid services, and again in 1993, when Congress tightened rules on transfer of assets. In 2000, Congress recognized the needs of caregivers by authorizing a caregiver support program under the Older Americans Act.

- At the center of the debate on long-term care financing is the Medicaid program. Medicaid, by default, has become the nation's primary source of public financing for people who need long-term care support. One-third of total Medicaid spending in FY2003 was devoted to long-term care—\$84 billion with about 67% for institutional care and 33% for home and community-based services. From 1990 through 2003, Medicaid long-term care expenditures grew at an annual average rate of 8% per year. Over the last 15 years, Medicaid long-term care spending has experienced a change in composition with a greater proportion of spending devoted to home and community-based services and a lower proportion for institutional care for persons with mental retardation and developmental disabilities.

- A number of themes of reform have been advanced over the last several decades. The principal debate in financing long-term care has focused on the respective roles of the public and private sectors. Because of the diverse socio-economic and disability characteristics of the population in need, one approach to financing reform may not fit all people. Defining the public and private sector roles in financing long-term care for these diverse groups may need to account for their varying needs and financial abilities.

A broad spectrum of proposals have been advanced over the years to change the way long-term care services are financed, ranging from social insurance programs to private sector approaches. While some policymakers are concerned about the cost of new social insurance programs, others are concerned about the affordability of certain private sector solutions, such as long-term care insurance, by moderate and low income persons.

Other subsidiary issues in the reform debate have included proposals to address the costs and quality of care; create more incentives for home and community-based care; assist family caregivers; and encourage individuals and families to plan for the potentially catastrophic costs of care. CRS is currently preparing a report summarizing a broad range of options that Congress might consider in revising the nation's long-term care system.

LONG-TERM CARE: CONSUMERS, PROVIDERS, AND SPENDING

The Long-Term Care Population

Long-term care support refers to a range of health and social services needed by persons who lack the capacity for self-care due to physical, cognitive, or mental illnesses that result in functional impairment and dependence on others for an extended period of time. Long-term care services include care in nursing homes and other institutions, as well as in home and community settings. The need for long-term care is measured by a person's inability to carry out basic human functions, or *activities of daily living (ADLs)*, such as bathing, dressing, eating, toileting, transferring from a bed to a chair, and getting around inside the home. Other measures include a person's need for assistance to live independently in the community, such as shopping, meal preparation, and light housework, known as *instrumental activities of daily living (IADLs)*. It is also measured in terms of people needing supervision with performing ADLs or IADLs when they have cognitive impairments, such as dementia. The amount of care needed varies depending upon a person's degree of impairment.

The need for long-term care affects persons with disabilities of all ages—children who are born with disabling conditions, such as mental retardation, or cerebral palsy, and remain disabled the rest of their lives; working age adults with inherited or acquired disabling conditions; and finally, persons aged 65 and older who have chronic conditions or illnesses. While the likelihood of needing long-term care assistance occurs more frequently in older ages, advances in medical care are enabling persons of all ages with disabilities to live longer.

Estimates of the number of persons of all ages who receive long-term care, need assistance with one or more ADLs, and reside at home or in facilities, range from 6.2 million to 8.0 million persons.³ Estimates would be higher if persons who receive assistance with IADLs only are included.⁴ Of all persons receiving assistance with at least one ADL and who reside at home or in nursing homes, about 56% are persons over age 65, and 44% are under age 65.⁵

The vast majority of adults, regardless of age—over 80%—receive care in home and community settings, *not* in nursing homes or other institutions. About 1.8 million adults—less than 20% of all adults receiving assistance—reside in institutions. Only the very old—persons aged 95 and older—have about an equal chance of being cared for in an institution or in the community (Table 1).

Table 1. Persons Aged 65 and Older Receiving Long-Term Care Services, 1999
(population in thousands)

Age range	Persons aged 65 or older	Percent receiving long-term care ¹	% Receiving long-term care in the community ²	% Receiving long-term care in institutions ³
Total, persons age 65 or older	34,459	5,479	3,824	1,654
Age				
65-69	9,443	5.7%	5.0%	0.7%
70-74	8,785	8.8%	7.2%	1.7%
75-79	7,305	13.6%	10.1%	3.5%
80-84	4,797	24.8%	17.3%	7.4%
85-89	2,601	39.8%	24.8%	15.0%
90-94	1,133	59.8%	33.7%	26.1%
95 years and older	0.396	72.1%	35.7%	36.4%

Source: Unpublished tabulations of the 1999 National Long-Term Care Survey by Brenda C. Spillman. The Urban Institute, 2003.

¹Receipt of long-term care is defined as receiving human assistance or standby help with at least one of six ADLs or being unable to perform at least one of eight IADLs without help.

²This does not include about 1.3 million persons with disabilities who use special equipment to manage their disabilities, but do not receive human assistance.

³This includes about 1.5 million persons in nursing homes and slightly more than 150,000 persons in other care facilities.

³This range is drawn from a variety of sources: the National Nursing Home Survey (1999); the Survey of Income and Program Participation (1997); the National Long-Term Care Survey (1999); the National Health Interview Survey (2002); and the National Medical Expenditure Survey (1996).

⁴Estimates of the number of persons who receive long-term care vary depending upon the numbers and types of ADL and IADL limitations, whether the person receives human assistance, standby help from another person, and other factors used for measurement.

⁵CRS estimates based on data from the National Health Interview Survey (NHIS) 2002, and the National Nursing Home Survey (NNHS), 1999.

People residing in institutions have more limitations than people residing at home. However, people receiving long-term care services at home are also highly impaired. Of the 1.6 million people residing in nursing homes with at least one ADL, about 91% were severely impaired with three or more limitations in ADLs (1999). Of 4.2 million persons receiving assistance at home, about 53% had limitations in three or more ADLs (2002). (Figures 1 and 2.)

Providers of Long-Term Care

The primary source of long-term care assistance is informal caregivers—families and friends of people with disabilities who provide assistance without compensation. Two-thirds of the functionally impaired elderly receiving care for impairments with ADLs or IADLs, and about 71% of such persons age 18-64, rely exclusively on informal, unpaid assistance (Table 2).

Table 2. Type of Care Received by Persons Aged 18 and Over Living in the Community

Persons receiving long-term care assistance in the community	Persons age 65 and older	Persons age 18-64
Total	3.7 million	3.4 million
Percent receiving care from unpaid providers only	66%	71%
Percent receiving paid care only	9%	6%
Percent receiving unpaid and paid care	26%	6%
Unknown	Not applicable	18%

Source: For persons aged 65 and older, National Long-Term Care Survey, 1999; estimates prepared by Brenda Spillman of the Urban Institute cited in *Older Americans 2004, Key Indicators of Well-Being*, Federal Interagency Forum on Aging Related Statistics, 2004. For persons 18-64, 1994 National Health Interview Survey, Disability Supplement. William Spector, et al., *Characteristics of Long-Term Care Users*, Prepared for the Institute of Medicine, 1998. Note: These estimates include persons with limitations in IADLs.

Estimates of the number of caregivers can range from 10-13 million people caring for people with moderate or severe disabilities, and can be many millions more, depending upon the characteristics of the population served and the amount and intensity of care provided. Research has shown that while adults of all ages provide long-term care assistance, people in middle to late middle age are most likely to be caregivers. While women are most likely to be caregivers, both men and women provide care. In addition, caregivers often have competing demands—about one-half are employed and one-third have minor children in the home.⁶

The aging of society will exacerbate demands on family caregivers for people with disabilities of all ages, not only for the elderly. Family caregivers are also vital for people with developmental disabilities. About 60% of the 4.6 million people with mental retardation or developmental disabilities receive care from family caregivers; of these people, more than one in six were living with caregivers over the age of 60. Many people with developmental disabilities are living longer with medical advances and supportive care. Some observers have pointed to a likelihood that people with developmental disabilities could live into their own retirement and outlive their family caregivers.⁷

In addition to the enormous amount of informal care provided by families and friends, the long-term care services system includes thousands of formal care providers. They range from institutional providers, including nursing homes and residential care facilities for people with mental retardation and developmental disabilities, to a variety of agencies and programs that provide a wide array of home and community-based services. These services include home health care, personal care, homemaker and chore assistance, adult day care services, home-delivered meals, transportation, and many others. In addition, assisted living facilities, adult foster care homes and other group homes provide both room and board as well as personal care and other assistance to people who have lost the capacity to live independently in their own homes.

Utilization and supply of the various formal care providers is of concern to policy-makers because these factors affect both cost and quality of care. The supply of nursing home beds varies widely among states as do the numbers and types of home and community-based providers. The average number of nursing home beds in the U.S. is 49 beds per 1,000 people aged 65 and older; but the number of beds per state

⁶ Administration on Aging, *National Family Caregiver Resource Guide*, Prepared by The Lewin Group, Inc., Washington, D.C., Aug. 2002.

⁷ David Braddock, Richard Hemp and Mary Rizzolo, *State of the States in Developmental Disabilities: 2004. Mental Retardation*, vol. 42, no. 5, pp. 356-370 and Mary C. Rizzolo, et al., *The State of the State in Developmental Disabilities, 2004*. In the 1970s, the mean age of death for people with mental retardation was 56 years; in 1993, it was 66 years.

ranges from 73 beds per 1,000 elderly people in Louisiana to 21 beds in Nevada. Similarly, the range in supply of personal and home care aides varies widely, from 45 aides per 1,000 elderly people in Texas to three aides per 1,000 elderly people in Mississippi, with a national average of 14 aides per 1,000 elderly people.⁸

Researchers predict that the increased numbers of people reaching age 65 as well as their increasing longevity will affect future demand for formal providers. One study predicts that 44% of those people who turned age 65 in 2000, will enter a nursing home during their remaining lifetimes. Almost one-third will have nursing home stays of three months or longer, and almost one-fourth will have stays of one year or longer. This same study predicts that the number of people age 65 years old who will have any nursing home use will more than double from 2000 to 2020 (from 891,000 to 1.8 million people) (Table 3). Policymakers may want to assess the utilization and supply issues affecting nursing facilities to determine whether other care modalities, such as greater supply of home care, assisted living and other residential care settings, may substitute for nursing home care for some people.

Table 3. Probability of Nursing Home Use at Age 65 for Various Years

Category of nursing home use	Persons turning age 65 in 2000		Persons turning age 65 in 2010		Persons turning age 65 in 2020	
	Number (thousands)	%	Number (thousands)	%	Number (thousands)	%
Category of use	2,013		2,625		3,922	
Any use	891	44	1,185	45	1,807	46
Three months or longer	651	32	873	33	1,344	34
One year or longer	469	23	632	24	977	25
Five years or longer	169	8	232	9	363	9
Timing of use						
Use in last year of life	793	39	1,057	40	1,618	41
Use only prior to last year of life	98	5	127	5	190	5

Source: Brenda C. Spillway and James Lubitz, "New Estimates of Lifetime Nursing Home Use: Have Patterns Changed?" *Medical Care*, vol. 40, no. 10, 2002.

Cost of Care. The cost of long-term care is related to the type, intensity, and duration of services needed by individuals, as well as the availability of informal assistance from family and friends. At one end of the spectrum, costs for 24-hour care in nursing homes can range from \$60,000-\$70,000 per year,⁹ and even higher in institutions for persons with developmental disabilities where costs can exceed \$100,000 per person. At the other end, the cost of providing home-delivered meals to a frail older person living at home may be quite modest.

Researchers and policymakers have long debated whether expanded access to home and community-based care for the nation's long-term care population is less costly than institutional care. This question is very complex and many factors must be considered, including how best to target home and community-based services and serve only those who would have entered a nursing home without the availability of expanded home care; what is the most effective mix of services to divert persons from institutional care; and how to assist informal caregivers who often make a difference in keeping their family members from entering an institution.

Long-Term Care Spending

A variety of public and private sources finance long-term care. Many federal programs assist persons needing long-term care services, either directly or indirectly through a range of health and social services, through cash assistance, and through tax benefits. While Medicaid is the primary source of public financing for long-term care, other programs, including Medicare, and social service programs, such as the Older Americans Act, provide assistance to persons who need long-term supports. No one program, however, is designed to support the full range of long-term care services needed by people with disabilities of all ages. Eligibility requirements, benefits, and reimbursement policies differ among major programs.

Of the \$1.44 trillion spent on all U.S. personal health care services in 2003, \$181.9 billion, or about 12.6%, was spent on long-term care (Figure 3). This amount includes spending on services in institutions (nursing homes and intermediate care

⁸Mary Jo Gibson et al., AARP, *Across the States, Profiles of Long-Term Care*, 2004.

⁹The MetLife Market Survey of Nursing Home and Home Care Costs, Sept. 2004. The average yearly rate for a private room in a nursing home was \$70,080 and for a semi-private room was \$61,685.

facilities for individuals with mental retardation (ICFs/MR)), and a wide range of home and community-based services, such as home health care services, personal care services, and adult day care, among others. Figure 3 (below) does not take into account the economic value of care provided to individuals with long-term care needs by uncompensated informal care providers.

Most public long-term care spending comes from the Medicaid program (a means-tested program jointly funded by federal and state governments). In CY2003, Medicaid spending accounted for 47.4% of all long-term care spending, or \$86.3 billion. After Medicaid, private out-of-pocket spending is the next highest source of financing for long-term care, accounting for 20.6% of all long-term care spending, or \$37.5 billion. Medicare plays a somewhat smaller role accounting for 17.8%, or \$32.4 billion, of the total. Private insurance accounts for about 8.7% of spending, or \$15.7 billion.

MEDICAID'S ROLE IN LONG-TERM CARE

At the center of the debate on long-term care financing is the Medicaid program. Medicaid, by default, has become the nation's primary source of public financing for persons who need long-term care support. Medicaid coverage of long-term care is intended to serve as a safety net for persons who cannot afford the cost of institutional care or home and community-based services. People turn to Medicaid when they have no more than \$2,000 in countable assets (excluding the person's home and certain other exempted assets). Generally, if they are not eligible for cash assistance under the Supplemental Security Income (SSI) program, they must apply most of their income to the cost of their care.

Financing of institutional care has dominated Medicaid long-term care spending for decades. However, in recent years, state Medicaid programs have played an increasingly larger role in financing home and community-based services.

Nursing Homes. In 1965, with the enactment of Medicaid, Congress created an entitlement to skilled nursing facility care. The Social Security Amendments of 1965 that created Medicaid required states to cover skilled nursing facility services and gave nursing home care the same level of priority as hospital and physician and other services.

These early legislative developments were the basis for the beginnings of the modern day nursing home industry. Significant growth in the number of nursing homes occurred during the 1960s—from 1960 to 1970 the number of homes more than doubled, from 9,582 to almost 23,000, and the number of beds more than tripled, from 331,000 to more than one million.¹⁰ (In 2004, there were about 16,000 nursing homes with 1.6 million beds.¹¹)

Intermediate Care Facilities for Persons with Mental Retardation. The early history of services to persons with mental retardation and developmental disabilities is characterized by the development of large state-financed institutions some of which were established during the latter part of the 19th century and continuing through the first part of the 20th century. In 1967, the number of residents in institutions peaked to almost 200,000 nationwide in 165 state-operated facilities.¹²

In 1971, federal financing for intermediate care facilities for the mentally retarded (ICFs/MR) was authorized under the Medicaid program; states that were able to meet the federal requirements governing care for persons with mental retardation in ICFs/MR shifted their state-financed facilities to the Medicaid program. Although care in ICFs/MR facilities is not a required service under state Medicaid plans, all states cover this care. Today, although some states are still faced with the legacy of large institutions, a major change has occurred toward care for persons with developmental disabilities in smaller, community-based residences as well as home-based services financed by Medicaid.

Home and Community-Based Services. Medicaid supports a range of home and community-based long-term care services, including home health care, personal care services, and a range of supportive services under the Medicaid Section 1915(c) waiver program. The latter program has become the centerpiece of home and community-based services policies for certain persons with disabilities, especially persons with mental retardation and developmental disabilities, in most states. About

¹⁰ U.S. Congress, Senate Special Committee on Aging, *Developments in Aging*, 1970, S.Rept. 92-46, Feb. 16, 1970, Washington, D.C. Cited from the *American Nursing Home Association Fact Book, 1969-1970*.

¹¹ Centers for Medicare and Medicaid Services (CMS), OSCAR, cited by American Health Care Association. [<http://www.acha.org/research>]. Data are for Dec. 2004.

¹² David Braddock, et al., *The State of the States in Developmental Disabilities*, University of Illinois at Chicago, American Association of Mental Retardation, Washington, 1998.

840,000 persons were served under this program in 2001. Under Section 1915(c) waivers, the most frequently provided services are personal care assistance and other home care services, habilitation,¹³ adult day care, case management, and respite services for caregivers.

Section 1915(c) allows the Secretary of the Department of Health and Human Services (DHHS) to waive certain statutory requirements to assist states in financing care at home and in other community-based settings for persons who, without these services, would be in an institution. States may waive the following Medicaid requirements: (1) statewideness—states may cover services in only a portion of the state, rather than in all geographic jurisdictions; and (2) comparability of services—states may cover state-selected groups of persons, rather than all persons otherwise eligible. In addition to waiving these requirements, states may use more liberal income requirements than would ordinarily apply to persons living in the community.

Federal law requires that persons eligible for home and community-based waiver services meet the level of care requirements (as defined by each state) provided in a hospital, nursing facility or ICF/ME. Level of care requirements describe the level and/or severity of functional limitations that individuals must have in order to be admitted to an institutional setting.

In implementing home and community-based waiver programs, States are constrained by a *budget neutrality test* in defining services they wish to cover. The law requires that the Secretary may not approve a waiver unless the average per capita expenditures for individuals provided waiver services do not exceed the average per capita expenditures that would have been paid if individuals had received Medicaid-supported institutional care. The Section 1915(c) waiver program has been particularly attractive to states because they have been able to control costs by limiting the number of waiver recipients and employing a variety of cost-management techniques, including fixed budgets, care management, and cost caps.

Medicaid Long-Term Care Spending

Medicaid is the dominant payer of long-term care services in this country paying for nearly one-half of all long-term care expenditures. Of *total* Medicaid spending—\$269 billion in FY2003—more than one-third was spent on long-term care.

Of total Medicaid long-term care spending—\$83.8 billion in FY2003:

- 67% was spent on institutional care (nursing homes and ICFs/MR); and
- 33% was spent on home and community-based services (home health, personal care and home and community-based waiver services).

From 1990 through 2003,¹⁴ Medicaid long-term care expenditures grew at an annual average rate of 8% per year. Institutional spending grew at an annual average rate of growth of 6%. States' efforts to focus on home and community-based services has resulted in a higher rate of growth for these services, growing at an average of 17% per year. Expenditures for the Section 1915(c) waiver program in particular grew at an average annual rate of 25%, and reached almost \$18 billion in FY2003. This increase has been a result of states' effort to contain the rate of growth in their nursing home expenditures and to provide expanded access to home and community-based services to persons with disabilities in order to respond to their preferences for this modality of care.

For many years, spending for institutional care has dominated Medicaid long-term care spending. However, over the last 15 years, Medicaid spending for long-term care has experienced a change in composition. In FY1990, 87% of long-term care spending was devoted to institutional care, declining to 67% by FY2003. In FY1990, about 13% of Medicaid long-term care spending was for home and community-based care, increasing to about 33% by FY2003, primarily as a result of increased spending under the Section 1915(c) waiver program. (Figure 4). This waiver program has been a significant source of support to care for persons with mental retardation and developmental disabilities. In FY2003, about three-quarters of waiver spending was for this population; the balance was spent on diverse groups of persons with disabilities, including the elderly and persons with physical disabilities. Despite the growth in home and community-based waiver services, many of these home and community-based waiver programs have been unable to meet the demand for services and maintain waiting lists.

¹³ Habilitation refers to services to assist individuals in developing skills necessary to reside successfully in home and community-based settings. It includes such activities as prevocational, educational, and supported employment.

¹⁴ Growth rates shown have been calculated on a calendar year basis.

LONG-TERM CARE: THEMES OF REFORM

Despite enormous spending on long-term care services, the nation lacks a comprehensive policy on financing of long-term care. Options to change the way long-term care is financed and delivered have been considered by Congress for over 35 years. The complexity of financing and delivering these services to diverse groups of persons with disabilities in a variety of care settings through multiple federal programs has been a challenge to federal and state governments.

Even after significant federal policy review on ways to improve the long-term care financing and delivery over the last two decades, Congress has not reached consensus of what road to take. The last time Congress made a systemic change in federal long-term care policy was in 1981 when it created the Medicaid Section 1915(c) home and community-based waiver program for persons with disabilities. In 1996, Congress clarified the tax treatment of long-term care insurance and allowed taxpayers who itemize a limited deduction for premiums. Other changes have included changes in Medicaid eligibility rules for long-term care services when in 1988, Congress provided financial protections for spouses of persons needing nursing home care and other Medicaid services, and again in 1993 when Congress tightened rules on transfer of assets. In 2000, Congress recognized the needs of caregivers by authorizing a caregiver support program under the Older Americans Act. That same year, Congress established a voluntary long-term care insurance program for federal employees, retirees, and family members. The last time that Congress comprehensively reviewed policy options for long-term care reform was in 1990 under the U.S. Bipartisan Commission on Comprehensive Health Care (known as the Pepper Commission).

Literally dozens of proposals have been considered and debated. For the past two decades, the principal debate in financing long-term care reform has focused on the respective roles of the public and private sectors. Proposals that have been debated are arrayed on a spectrum. On one end, are proposals for new social insurance programs that would expand or replace current programs, perhaps relying on payments from individuals through cost-sharing, premiums and deductibles, rather than means-testing and spend-down requirements under Medicaid. At the other, are proposals that rely on private sector financing, such as long-term care insurance, with the rationale that the nation cannot afford the additional tax burden of another entitlement program.

Other subsidiary issues in the reform debate have included proposals to address the costs and quality of care; create more incentives for home and community-based care; assist family caregivers; and encourage individuals and families to plan for the potentially catastrophic costs of care.

The following presents broad themes of proposals that have been advanced.

Insurance Options. Many believe that the need for long-term care is an insurable event where risk of needing services is not effectively spread across the population through pooled risk. Proposals for expanding insurance for long-term care, either on a mandatory or voluntary basis, have been considered in the past. For example, the Pepper Commission took the stand that long-term care should be treated as an insurance event whose risk can be spread through both public and private coverage.¹⁵ In 2001, Citizens for Long-Term Care, a coalition of over 60 national organizations representing major national associations of long-term care providers, insurers, and advocacy groups also came to this conclusion.¹⁶

Some people believe that a social insurance approach is necessary to assure universal coverage (at least for a defined target population) since many persons with disabilities will not be able to afford private coverage. Such a program would have to be designed to assure affordability for both the public sector as well as individual participants. Others believe that costs of a new or expanded social insurance program would be prohibitive. Some proposals have suggested government-sponsored voluntary insurance programs. Such approaches could be designed to attract persons in middle ages or younger who want to plan for future long-term care costs, but may not attract sufficient numbers of persons to create an insurance pool. Also, voluntary programs may have to be designed to encourage participation by persons at the lowest economic scale.

Options to create incentives for individuals to purchase private long-term care insurance have been proposed frequently. The number of policies sold has increased in recent years with over 9 million policies sold from the inception of the market

¹⁵U.S. Bipartisan Commission on Comprehensive Health Care, The Pepper Commission, *A Call to Action*. Final Report, 1990, Washington, D.C., p. 119.

¹⁶Citizens for Long Term Care, *Defining Common Ground, Long Term Care Financing Reform in 2001*, Feb. 2001, Washington. D.C., p. 3.

through the end of 2002.¹⁷ The market grew at an average of 18% each year from 1987 to 2002.¹⁸ For some people, insurance is a viable option and can assist them in paying for catastrophic long-term care expenses. However, policies can be expensive for purchase by low and moderate income persons.

Another possible means of providing access through an insurance approach might be to extend Medicaid coverage for people who have higher income or more assets than current Medicaid tests allow, and then requiring them to pay premiums and cost-sharing (as is the case in certain Medicaid state optional programs, such as for working disabled under the Ticket To Work program). Depending upon how it is structured, such an approach could assist persons with catastrophic costs according to their ability to pay. However, policymakers may be more concerned about containing, rather than expanding, long-term care benefits.

Shared Public and Private Options. Some observers argue that the complexity of long-term care financing for diverse groups of individuals with disabilities—children and working age persons with disabilities, as well as the elderly, with differing types and severity of impairments—necessitates a multi-pronged strategy of financing and delivery reform. Because of the diverse socio-economic and disability characteristics of the population in need, one approach to financing reform may not fit all people. Defining the public and private sector roles in financing long-term care for these groups would need to account for their varying needs and financial abilities.

Approaches might combine some aspects of incentives for private financing as well as public financing. Strategies that would promote both private insurance for those who could afford premiums, as well those that would preserve safety net programs for those who cannot afford catastrophic expenses or private financing solutions, might be sought.

Policymakers will have to evaluate the proposals in light of a number of dimensions. This would include their potential budgetary impact, including their potential to increase total costs, to decrease an otherwise expected rate of increase in costs in one sector of care (for example, by substituting less costly per beneficiary services for more costly services), or across multiple programs, or within an individual program. Other dimensions might include the proposals' potential effect on aspects of service delivery goals, such as assisting persons to reside in community settings rather than in institutions, and assisting informal caregivers to continue their support for family members.

Rebalancing Institutional and Home and Community-Based Services Options. Over the last three decades, a constellation of proposals has been made to level the playing field so that home and community-based services receive the same priority as institutional services under Medicaid. A factor sharpening recent federal and state policy attention on home and community-based care are legal actions that have taken place in states as a result of the 1999 Supreme Court decision, *Olmstead v. L.C.* (528 U.S. 581). In this decision, the Court stipulated that, under certain circumstances, institutionalization of persons who could live in community settings, and desire to do so, violates the Americans with Disabilities Act (ADA).

Many people refer to Medicaid as having an "institutional bias" since nursing home care is an entitlement for persons who can meet eligibility tests, but the Section 1915(c) waiver program, the primary source of financing home and community-based services, is not. Numerous proposals have been made to reformulate the Section 1915(c) home and community-based services waiver program (e.g., by eliminating its "wavier" nature and changing certain eligibility features) and to expand personal care services. Some believe that such approaches would give this type of care the same priority as institutional care. Others are concerned that if such programs were expanded without controls on numbers of persons to be served, costs would increase.

Such approaches would have to evaluated in terms of total cost. Nevertheless, some state administrators have maintained that it is possible to control the rate of increase in long-term care costs that would have occurred by instituting systemic reform that includes (1) controlling access to institutional care and limiting its supply; (2) expanding home and community-based care for those who otherwise need institutional care; (3) and balancing consumer choice with appropriate cost controls.

Policy Questions

The answers to a number of policy questions will influence the future direction of federal policy:

¹⁷This number does not include the number of policies dropped, canceled, or lapsed.

¹⁸American Health Insurance Plans, *Long-Term Care Insurance in 2002*, June 2004., Washington, D.C.

- Given expected demographic changes as a result of population aging, and expected escalating public spending for long-term care, what should be the respective roles for the public and private sector?
- Should any revised public long-term care strategy be universally available to a specific group of people, or should it be targeted on the basis of income and/or disability? If it is available on the basis of income, how should income and assets should be considered?
- What is the best way to provide individuals with incentives to save personal funds for long-term care and/or purchase insurance to protect themselves from high out of pocket expenses for long-term care?
- How can individuals and families be encouraged to plan for long-term care expenses as part of planning for a secure retirement?
- Can federal policies be changed to better assist family members and other informal caregivers who already provide most long-term care support?
- Can federal policies be changed to address access issues for services for those who do not have family caregivers?
- To what extent do public programs need to be balanced to support increased home and community-based services? How can we assure that all modalities of care meet quality measures?

As it considers these questions, Congress might continue making incremental policy changes like those of the past two decades. On the other hand, many believe that incremental changes may not be sufficient to prepare for future needs and that larger scale reform may be necessary.

Figure 1. LTC Recipients, Age 65 and Older, at Home, by Level of Need

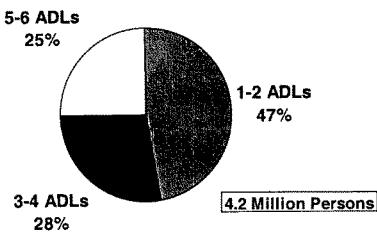
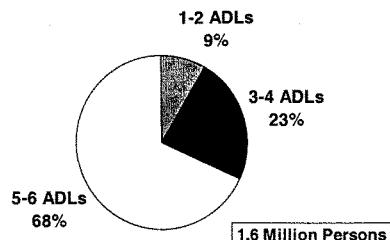


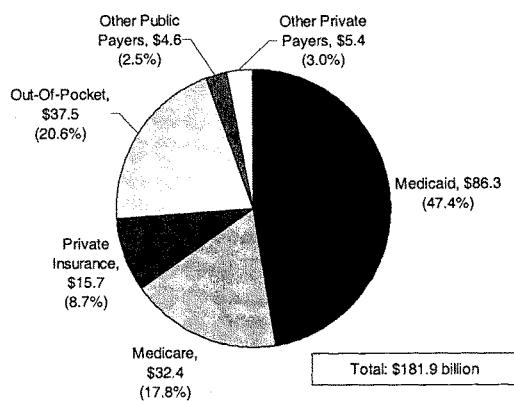
Figure 2. LTC Recipients Age 65 and Older, in Nursing Homes, by Level of Need



Source: CRS computations based on data in B.C. Spillman, *Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost*, prepared for Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Feb. 2003. Original source of data: National Long Term Care Survey (1999).

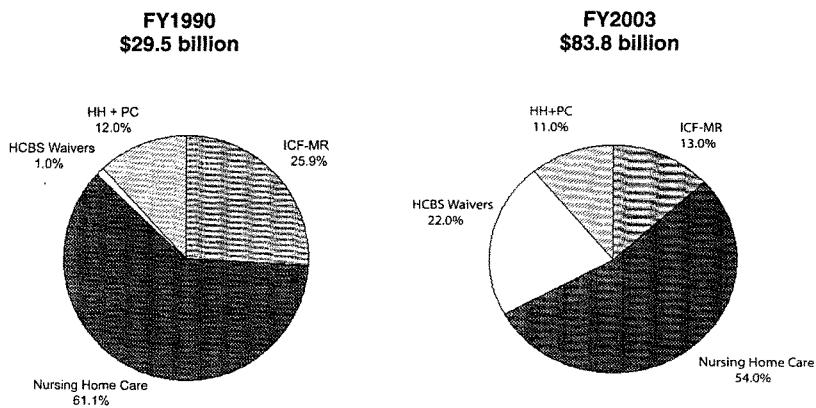
Notes: Includes long term care recipients (5.8 million) with at least one ADL limitation. These individuals may be using equipment or receiving either active or standby help with their ADLs. The population size in these charts differs from estimates presented in Table 1 for two reasons: (1) Table 1 includes persons with IADL limitations and these figures do not; and (2) long term care recipients who use equipment to manage their ADL limitations are included in these figures but not in Table 1.

Figure 3. Long-Term Care Expenditures, by Payer, CY2003
(expenditures in billions)



Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home and community-based waivers. Does not include spending for hospital-based nursing home and home health for other payers.

Figure 4. The Changing Face of Medicaid Long-Term Care Spending



Source: Congressional Research Service (CRS) analysis of data and estimated expenditures from CMS-Form 64.
HH+PC refer to home health and personal care services.

Mr. DEAL. Thank you. Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI

Ms. IGNAGNI. Thank you, Mr. Chairman and Mr. Brown. We appreciate the opportunity to testify this afternoon, and very much appreciate the focus that the committee is placing on the issue of long-term care.

As we prepared for today's testimony, and as you grapple with the issue, we wanted to leave you with the proposition that has been stated over and over today, and most recently by Mr. Page, that it is time to enlarge the healthcare discussion, to broaden it and to have a paradigm shift to recognize that we can't think in silos about healthcare any more. We need to break down the barriers between acute care and long-term care, and begin to think about a continuum of care.

And when you look at the data, almost half of the population over 65 will need nursing home care as they go through their lives, and the average stay is roughly 2.4 years. We also know that Medicaid has been in silos. The focus has been, in reaching out to the private sector for tools and techniques, has been primarily, until recently, on the acute care side. We think we have not only a great deal to contribute on that side, but also, something significant to contribute to shore up the Medicaid program on the long-term care side.

Finally, in our view, tax policy has held the Nation back, because it hasn't really kept up with supporting families who want to protect themselves, who are able to and would like the opportunity. So recognizing that the committee is seeking the balance point between public and private sector strategies, as my colleagues have observed, we have tried to provide you information about three things.

First, what tools our members have brought to the Medicaid program, not only to contain costs, but to preserve benefits to avoid cutbacks and to preserve value, and to increase value. We have provided a lot of data. We would be delighted to provide more. There is a real opportunity, a positive story to tell. We think we can do more in the area of long-term care, and we are pleased that States are turning to our members to use their tools and techniques in that arena.

Second, we have provided information. There has been a great deal of discussion today about how the long-term care market works. We have also, third, tried to provide information and specific strategies that could be considered to encourage families who would like to purchase private long-term care insurance.

The point we would like to leave you with is by not having affirmative policy, you have created a policy. It has been we have backed into it. It is not organized, but there is a policy here, where families who want to save and protect themselves in the future aren't supported. For example, we have had some discussions about the above the line deduction. There is also the issue of flexible benefit plans not being able to be used for long-term care purchase, 125 cafeteria plans. Those issues, we think, could be considered.

We know that is not necessarily in the province of this committee, but as you grapple with the issues of what to do, and where

to put that balance point, we thought it was important to raise. We also think that it is unfortunate that States have to get exceptions to move in the area of home and community-based care, rather than being allowed to do that as a matter of course, and there was certainly a great deal of discussion about that with Dr. McClellan.

In our view, the Nation can do better. We think that there can be strategies that could be tangibly undertaken very quickly. We have tried to provide information on the cost of private insurance policies. We have provided and anticipated questions about lapse rates, and how long people keep long-term care policies. I would like to affirmatively discuss consumer protections. Our members strongly support the HIPAA requirements. We have supported the model requirements, and we have worked hand in hand with the NAIC in developing those model requirements.

So in summary, Mr. Chairman, Mr. Brown, we have suggested three categories of tangible strategies. First, to preserve benefits in the Medicaid program, we have talked about the kinds of cost effectiveness—I apologize for the voice—I have asthma, and these allergy days are particularly difficult for people in that condition. We have talked about cost effectiveness, and higher quality services that we can bring to Medicaid. We have also talked about the tax incentives to expand access to families who want to save for long-term care. And we have talked about expanding partnerships and hopefully have given you some information that you can use on the partnerships to consider a direction for expanding those, and expanding access, and making it possible to put the balance point in the right place between public and private sector strategies.

Thank you, Mr. Chairman, and I apologize about the voice.

[The prepared statement of Karen Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS

Good morning, Mr. Chairman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify about long-term care and the Medicaid program. We share your commitment to meeting the long-term care needs of our nation's aging population and, at the same time, ensuring that Medicaid's financial stability is not threatened by the high costs associated with long-term care.

In our view, it is time for a paradigm shift in the health care discussion. Our current health care system focuses primarily on treating episodes of acute illness, rather than managing chronic conditions. This is true despite the fact that 20 percent of all Medicare beneficiaries—chronically ill patients with five or more medical conditions—accounted for more than two-thirds of the Medicare program's costs in 2004. Likewise, long-term chronic care management is a key cost issue for Medicaid. Our tax system has followed a similar pattern by orienting incentives toward the coverage of acute care benefits. To meet these challenges, the nation needs to broaden the health care discussion to focus on the continuum of health care services that people need throughout their lives.

In the next 30 years, more than half the U.S. population will be living with at least one chronic condition. Chronic illnesses such as cancer, diabetes, Alzheimer's disease and hypertension complicate age-related health problems and increase the likelihood of needing long-term care. Currently, nearly half of all nursing home residents have Alzheimer's disease. By 2050, the Alzheimer's Association estimates that 14 million baby boomers, nearly one in five, will find themselves living with the disease. We need to make major adjustments to address 21st-century realities and our

aging population. At the same time, we need to explore a range of public-private partnerships that could make long-term care costs more predictable and expand service options for consumers.

This should be a particularly important priority considering that Medicaid currently covers about 45 percent of all long-term care expenditures. Even though fewer than 10 percent of Medicaid beneficiaries use long-term care services, more than one-third of total Medicaid spending is devoted to long-term care.

My testimony today will focus on three areas:

- (1) What our members are doing to contain costs and improve quality in Medicaid by working in partnership with the states;
- (2) An overview of the long-term care insurance market and the role that long-term care insurance can play in relieving financial pressure on Medicaid; and
- (3) Tangible policy changes that could be pursued to assist families interested in saving for long-term care.

The activity in these areas will show that AHIP's members are actively engaged in providing consumers with both private and public options for meeting the challenges raised by long-term care and chronic conditions.

THE SUCCESS OF PRIVATE SECTOR STRATEGIES IN MEDICAID

Health insurance plans have made an important contribution toward making it possible for Medicaid programs to use their limited resources to expand access, improve quality, provide transportation services, and take other steps to better serve beneficiaries.

In a number of states, our members are participating in initiatives to improve the quality of long-term care while stretching Medicaid dollars. Most of these programs—including initiatives in Texas, Arizona, Massachusetts, Wisconsin, New York, Florida and Minnesota—seek to decrease the need for nursing home care, reduce hospitalizations, and increase the number of elderly and disabled who can be better served in home and community settings. For beneficiaries, this means improved health outcomes and the opportunity to receive care in a familiar setting of their own choice.

These programs not only save money and improve the quality of care, but also deliver extremely high patient satisfaction. In Texas, the STAR+PLUS program saved the state \$17 million dollars in the first two years in just one county, and reduced emergency room use by 40 percent and inpatient admissions by 28 percent. In Minnesota Senior Health Options—which combines health care and support services into a seamless package—Medicaid enrollees report a 94 percent satisfaction rate with their care coordinators.

Further successes are documented in an July 2004 report¹, conducted by the Lewin Group, which provides a synthesis of 14 separate research studies that demonstrate the cost savings to states and the high quality health care offered by Medicaid managed care programs. These savings have been particularly important as states confront Medicaid funding shortfalls that have challenged their ability to deliver services without cutting benefits or eligibility.

The studies examined by this report attribute significant cost savings to Medicaid managed care. One study, for example, found that Michigan's Medicaid managed care program yielded cost savings of 14 percent in FY 2002, 16 percent in FY 2003, and 19 percent in FY 2004. Another study, focusing on Wisconsin, measured savings of 7.9 percent in 2001 and 10.2 percent in 2002.

A number of other studies focus more narrowly on specific services or population subgroups. One study found that Arizona's managed care program, which fully capitates prescription drug costs, delivered pharmaceuticals to the aged, blind and disabled at a per-member, per-month cost of \$112.21 in 2002, the lowest figure in the nation and 38 percent below the national average. Another study found that cost savings of approximately 10 percent were achieved by moving adult women in Hennepin County, Minnesota from fee-for-service coverage to Medicaid managed care coverage.

The report notes that these cost savings are largely attributable to decreases in utilization of inpatient hospital services. For example, preventable hospitalizations in California were found to be 38 percent lower in managed care than in fee-for-service for mothers and children enrolled in Medicaid—and 25 percent lower in managed care than in fee-for-service for Supplemental Security Income (SSI) recipients.

¹The Lewin Group, *Medicaid Managed Care Cost Savings—A Synthesis of Fourteen Studies*, July 2004

The report further states that in addition to achieving cost savings on behalf of beneficiaries, Medicaid managed care programs have improved access to care for Medicaid beneficiaries in most cases. It also indicates that both state programs and individual managed care organizations have earned high satisfaction ratings from enrollees.

Another report², released by AHIP in March 2005, outlines numerous examples of how health insurance plans serving Medicaid beneficiaries have implemented programs that are improving the health care of beneficiaries and providing value to state governments through innovative and cost-effective programs. The progress achieved by these pioneering programs is evidenced by this sample of the report's findings:

- **Access to Care:** Medicaid beneficiaries served by health plans in New York City report that they have better access to care than patients in the fee-for-service program, and are more likely to have a regular source of care and to seek care at a doctor's office rather than in emergency rooms. As a result, these beneficiaries are more likely to receive the appropriate primary care and preventive services than their counterparts in the fee-for-service program.
- **Prenatal Care:** Infant mortality rates in Rhode Island have dropped dramatically—from 4.5 deaths per 1,000 births to 1.9 per 1,000—since health insurance plans began providing care for pregnant women enrolled in the state Medicaid program.
- **Asthma:** Children with asthma enrolled in Medicaid health insurance plans in Wisconsin are significantly less likely to require hospitalization than asthmatic children in the state's fee-for-service programs. The lower hospitalization rate for these children means that they are enjoying better health and are likely to have fewer absences from school.
- **Diabetes:** Among Medicaid participants with diabetes in North Carolina, those served by health insurance plans are three times more likely to properly monitor and control their blood glucose levels. This translates into better health status for diabetes patients—with fewer complications that otherwise would increase the threat of blindness, amputations, and other health problems.

Our members have designed programs that work for Medicaid beneficiaries and also for the states. The successful programs implemented by health insurance plans demonstrate quality improvement and cost containment through innovative outreach programs that meet budgetary needs and provide access to more coordinated and effective health care.

THE ROLE OF PRIVATE LONG-TERM CARE INSURANCE

The number of individuals purchasing long-term care insurance has grown dramatically in recent years. Since 1996, the number of policies purchased has more than doubled, increasing from 4.9 million to about 10 million policies sold.

Policies contain a wide range of benefit options at moderately priced premiums. For example:

- Long-term care insurance plans offer coverage of nursing home, assisted living facility, home health care, hospice care, respite care, and certain alternate care services not listed in the policy.
- Other common benefits include: care coordination or case management services, support with activities of daily living, medical equipment coverage, home-delivered meals, spousal discounts, survivorship benefits, and caregiver training.
- Plans contain provisions that guarantee their renewability, have a 30-day "free look" period, cover Alzheimer's disease, provide for a waiver of premiums once a claim is processed, and give policyholders the option of covering nursing home stays without limits or caps.
- Age limits for purchasing coverage also are expanding. Our members now offer individual policies to people as young as 18 and as old as 99. In addition, recognizing that consumers want to plan ahead for their long-term care needs, plans offer inflation protection for the dollar value of a purchased benefit at an annual 5 percent compounded rate, funded with a level premium that stays the same from one year to the next. Companies also offer plans that have a non-forfeiture benefit that allows beneficiaries to retain some benefits if they lapse their policy.

The growth in employer-sponsored plans is especially encouraging, since individuals with employer coverage will not be forced primarily to depend on their states for assistance in meeting their long-term care expenses. The average age of the employee electing this coverage is 45—compared to an average age of 60 for persons

²AHIP, *Innovations in Medicaid Managed Care*, March 2005

who buy long-term care insurance outside of the employer-sponsored market. To date, close to 2 million policies had been sold through more than 5,600 employers, and accounted for one-third of the sales in 2002.

Premiums for long-term care insurance policies depend on multiple factors, including the entry-age of the policyholder and comprehensiveness of the benefit package selected. At the same time, the committee should be aware that average premiums have remained stable over time. AHIP estimates that a vast majority of long-term care policies currently in effect today have never experienced a rate increase. In addition, within the past few years there have been significant enhancements to long-term care insurance (for example, prior hospitalization requirements have been eliminated and benefits have been expanded to include coverage in assisted living facilities, adult day care and home health care, in addition to nursing home care), and therefore that give buyers more benefits for their premium dollars.

Table 1 illustrates the average cost of long-term care premiums, depending on when the policy is purchased.

Table 1: Average Annual Premiums for Leading LTC Insurance Sellers in 2002

Age of Purchaser	Base	With 5% Comp. Inflation Protection (IP)
40	\$422	\$890
50	\$564	\$1,134
65	\$1,337	\$2,346
79	\$5,330	\$7,572

NOTE: Premiums are generally for a \$150 daily benefit amount, four years of coverage, and a 90-day elimination period.

Consumer Protections—Strengthening the Market

A vital component of this effort to strengthen the market for long-term care insurance is the adoption of robust standards for consumer protection. Because we recognize that consumer protections are critical toward engendering confidence in the market, AHIP and our member companies are committed to providing quality products, transparency in our products, and consumer choice. We view these protections as key to giving consumers confidence, expanding the market, and providing viable solutions to work hand in hand with Medicaid coverage for the poor.

In the past, there have been questions about post-claims underwriting. Our position is that this is never justifiable. On the other hand, efforts to detect and prevent fraud should not be viewed as post-claims underwriting. AHIP supports the strong stand taken on this issue by the National Association of Insurance Commissioners (NAIC). We also support the NAIC's most recent Long-Term Care Insurance Model Act and Regulations and the Health Insurance Portability and Accountability Act's (HIPAA) consumer protections for long-term care insurance.

To give the committee a broad picture of the value of the HIPAA provisions, below are some of the key requirements:

- requiring policies to guarantee renewability;
- specifying the only circumstances when coverage could be canceled or rescinded, such as when the applicant committed fraud to obtain coverage;
- requiring “free-look” periods immediately after issue and grace periods for premium payments;
- limiting the circumstances where benefits need not be provided, such as in the case of alcoholism or drug addiction;
- requiring numerous disclosures, including an outline of coverage, and building in notice and other safeguards to prevent unintended lapses of policies; and
- establishing minimum standards for home health benefits; and requiring that policies be offered with inflation protection and non-forfeiture of benefits provisions.

In addition, federal legislation enhancing the tax treatment of long-term care insurance contracts should include components of the 2000 NAIC Models. As an example, AHIP recommends that the Model provisions relating to the benefits consumers are to receive if they choose not to continue their policy and required disclosure to consumers relating to rate stability be added as new standards for tax-enhanced long-term care insurance contracts.

HOW TO SUPPORT FAMILIES THAT WANT TO SAVE FOR LONG-TERM CARE

A. Federal Tax Incentives

AHIP supports federal legislation to enact both an above-the-line tax deduction for long-term care insurance premiums—which means that they would be deducted directly from a taxpayer’s adjusted gross income (the “line”)—and a tax credit of up to \$3,000 for those with long-term care needs or their caregivers. This legislation has been introduced in every legislative cycle since 1999-2000 and the current level of support reflects growing congressional interest in this issue.

The proposal for an above-the-line tax deduction would allow taxpayers to claim a tax deduction regardless of whether they itemize their deductions and regardless of whether they have other medical expenses. For example, a person who pays \$1,500 in premiums for long-term care insurance could reduce his or her taxable income by the full \$1,500 under this proposal.

By contrast, current law allows taxpayers to deduct premiums for long-care term insurance only if they itemize deductions and only to the extent that their medical expenses exceed 7.5 percent of their adjusted gross income. In other words, a person with an adjusted gross income of \$40,000 must have \$3,000 in medical expenses before he or she can claim any tax deduction for long-term care insurance premiums or any other medical expenses. Because this threshold is so high under current law, fewer than five percent of all tax returns report medical expenses as itemized deductions. An above-the-line tax deduction would eliminate this 7.5 percent threshold and allow all long-term care insurance policyholders to claim a tax deduction.

AHIP also supports legislative provisions that would enable employers to offer long-term care insurance as an option under cafeteria plans, which allow employees to customize their benefits packages, and under flexible spending arrangements, which allow employees to use pre-tax dollars to pay for medical expenses not covered by health insurance.

Allowing employees to purchase long-term care insurance on a pre-tax basis through these popular employee benefit arrangements would allow more families to purchase coverage. Moreover, this would put long-term care insurance on a level playing field with other employer-sponsored benefits—such as 401(k) contributions—that are not taxed.

As Congress considers federal tax incentives, we urge lawmakers to recognize that more than 20 states have enacted enhanced tax incentives for the purchase of long-term care insurance. These states are: Alabama, California, Colorado, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia, and Wisconsin. These state laws have taken an important first step to enhance the affordability of long-term care insurance. By enacting an above-the-line tax deduction at the federal level, Congress can create a more powerful incentive—with the states working in partnership—for all Americans to protect themselves against the financial risk of long-term care needs.

B. Partnerships

AHIP also supports the expansion of public-private long-term care “partnerships” similar to those that currently operate in New York, California, Connecticut, and Indiana into a nationwide program. These partnerships allow consumers in these states to purchase long-term care insurance with the understanding that if their policy benefits are exhausted, the government will cover the costs of their continuing care through Medicaid without first requiring them to “spend down” their life savings and become impoverished. There are two partnership models:

- The “dollar-for dollar” model allows beneficiaries to protect a specified level of assets equal to the amount of long-term care insurance they purchase. If a beneficiary purchases \$100,000 of coverage, he or she is assured that \$100,000 of his or her assets will be exempt from any Medicaid “spend down” requirements that otherwise would apply.
- The “total asset protection” model allows beneficiaries to protect all of their assets, provided that they purchase a long-term care policy for a minimum number of years, typically three or four years.

AHIP envisions that a partnership model implemented on a national basis would encourage the growth of the long-term care insurance marketplace in a more effective and cost-efficient manner. This national or federal model should mirror HIPAA long-term care tax-qualified requirements and would allow Medicaid protection in all states, regardless of where one purchases a long-term care policy.

Among more than 180,000 partnership policies that have been sold in these states since 1992, only 89 individuals have exhausted their private benefits and accessed Medicaid benefits, and almost 30 percent of policyholders surveyed said they would

not have purchased a long-term care policy in the absence of the partnership program.

C. Other Strategies

To meet the challenges presented by long-term care, policymakers should focus broadly on as many bold and creative ideas as possible. In addition to the proposals already discussed, a number of other innovative approaches may be worth pursuing as part of a multi-faceted strategy for financing the growing costs associated with long-term care:

- State-based and national education campaigns could play an important role in making consumers aware of their options for protecting themselves from the risks associated with long-term care costs. The existing CMS Long-Term Care Awareness Campaign, developed for five states, could be expanded to other states using resources jointly provided by CMS, state Medicaid programs, long-term care insurers, long-term care providers, and other stakeholders.
- Any number of innovative new partnerships between long-term care insurers and Medicaid programs could be explored. One possibility would be a partnership in which long-term care insurers would manage a state's Medicaid long-term care population. Another option would be to expand state Medicaid managed care programs to cover the entire continuum of health care services including acute care and long-term care.
- State-based CMS demonstration programs could be expanded to help states meet their long-term care costs in Medicaid. This approach would allow states to test innovative partnerships as part of an incremental approach to developing broad-based solutions.

Consumer Education and Transparency

As the market grows and adapts to consumer needs and expectations, the private sector and government at all levels should encourage a broad consumer education campaign. The NAIC Models could also serve to enhance the ability of consumers to compare products and make more informed decisions about need and suitability. In fact, the NAIC models provide guidance on suitability to help consumers select appropriate products and to ensure that agents are in turn selling products compatible with a consumer's particular needs.

Finally, I would like to mention that AHIP actively works with federal and state long-term care education campaigns, and we produce and regularly update a "Guide to Long-Term Care Insurance." The Guide includes advice on how families should evaluate their long-term care needs, what the costs are, and how to choose long-term care insurance coverage. To date, we have distributed over 1 million copies of the Guide.

We have also partnered with the General Services Administration's Federal Consumer Information Center (FCIC), which has identified this publication as its "guide of choice" on long-term care insurance. The Guide is available to consumers, at no charge, through the FCIC by phone [1-888-8 PUEBLO], on the web at www.pueblo.gsa.gov/cic—text/health/lte/guide.htm.

CONCLUSION

We hope this information about the long-term care market, what our members already are doing to partner with states under Medicaid, and policy solutions for providing expanded access to coverage are useful to the committee. If these recommendations are implemented, there will be tangible benefits³ for consumers and for Medicaid and Medicare:

Potential Benefits to Consumers

Having long-term care insurance allows those with chronic illnesses and the disabled to remain in their homes. Approximately half of patients and family caregivers interviewed by trained nurses and social workers said that in the absence of their long-term care insurance benefits, the patients would not be able to remain in their homes and would have to seek institutional alternatives.

We know that consumers with private long-term care insurance receive an average of 14 more hours of personal care per week than similarly disabled non-pri-vately insured elders. Consumers with long-term care insurance are 66 percent less likely to become impoverished to pay the costs of long-term care, and long-term care insurance reduces the out-of-pocket expenses of disabled elders. The average reduction in out-of-pocket nursing home costs is between \$60,000 and \$75,000 and can total more than \$100,000.

³ LifePlans, Inc., *Benefits of Long-Term Care Insurance*, September 2002

Potential Benefits to Medicaid and Medicare

Long-term care insurance can reduce state and federal Medicaid expenditures and federal Medicare home health expenditures. Medicaid savings are projected to total about \$5,000 for each policyholder with long-term care insurance and Medicare savings are estimated to exceed \$1,600 per policyholder.

Aggregate savings to Medicare and Medicaid for the current number of policyholders are estimated at about \$30 billion. These savings will grow as more people acquire policies and the average age of purchasers continues to decline.

AHIP and our member companies look forward to working with the subcommittee to address the challenges associated with long-term care and Medicaid. We are eager to share our ideas and contribute to a constructive debate on this issue. We also support efforts to establish a Bipartisan Commission on Medicaid. If Congress provides for such a commission, we will be pleased to work with this body to contribute to the discussion about steps that can be taken to strengthen Medicaid to better meet the health care needs of beneficiaries.

We appreciate the opportunity to testify on these important issues and look forward to your questions.

Mr. DEAL. Thank you very much. Mr. Moses.

Mr. MOSES. Thank you, Mr. Chairman, Mr. Brown, members.

Mr. DEAL. Turn your microphone on, please. I believe—or get closer. One or the other.

STATEMENT OF STEPHEN A. MOSES

Mr. MOSES. Thank you for this privilege of addressing you on an issue that has been my personal and professional passion for 22 years, starting with, as a career, U.S. Government employee with the Health Care Financing Administration, later with the Office of the Inspector General of the Department of Health and Human Services, and then in the private sector, and now, in the nonprofit sector.

I wanted to focus today on a couple of questions. Really, what are we talking about here in the area of asset transfers, and why is there so little empirical evidence of how widespread this practice is? Really, asset transfer is an oversimplification. What we are talking about here is Medicaid estate planning, which is all of the techniques that are used to help people qualify for Medicaid without spending down, by either sheltering or divesting assets. It may involve asset transfers. As you know, you can give away any amount of assets, as long as you do it 3 years in advance, or put assets into trusts within 5 years. You can give away half the assets and qualify in—with half the penalty. It is called the half a loaf strategy. One can give away double the cost of a nursing home in many States, at least the cost of a nursing home in all States without incurring a penalty beyond the current month, and of course, assets can be transferred in unlimited quantities between spouses, and that is a technique often used to avoid estate recovery.

But Medicaid planning is much more than asset transfers. It is purchase of exempt assets. You can retain a home and all contiguous property, regardless of value. You can have a business, including the capital and cash-flow, of unlimited value. You can purchase prepaid burials, not only for the Medicaid recipient, but for the entire family. You can have a car, a business, term life insurance in unlimited value. A common technique is to pay children for their help, transfer assets, transfer a home while retaining a life estate, get a Medicaid-friendly annuity, use a life care contract. I have even seen many times the recommendation of a divorce.

Now, why is it that, since we all know this is going on, there is so little empirical evidence? I think there are basically two reasons. First of all, it is kind of a dirty little secret. Adult children who take early inheritances and put their parents in nursing homes on welfare are a little bit ashamed, so they don't talk about it. Seniors whose assets are taken are usually cognitively impaired, or somewhat intimidated, because they would like to give something to their children. They don't talk.

Medicaid planners can easily hide from scrutiny, because of the attorney-client privilege. And the other primary source we might have for information is nursing home staff or State Medicaid staff, and they can't talk. They are silenced by confidentiality. But despite these obstacles, it is quite possible to get the truth, and I have done many studies at both the national and State level which document that. We have provided a statement, and a list. Medicaid eligibility workers have told me in numerous States that upwards of 80 percent of everyone in long-term care paid for by Medicaid has done some form of asset divestiture or asset sheltering.

So why don't we have more solid empirical evidence? I would submit to you that this is almost a conspiracy of ignorance. There is a distinct ideological bias among academics, foundations, and think tanks. The research money is controlled by people who promote public financing, but pooh pooh all of the private financing alternatives, and I would give as examples Georgetown, Kaiser, Robert Wood Johnson, Brookings, the Urban Institute. The conservative and libertarian think tanks, on the other hand, have mostly ignored Medicaid and long-term care to focus on Social Security and Medicare. And I see a real irony in this, because it seems to me that the left end of the political spectrum should be even more concerned about the abuse of Medicaid, for the simple reason that why would we use our scarce public welfare resources to indemnify the upper middle class heirs of affluent seniors, when they are all probably a bunch of Republicans anyway?

What is the real problem here, because I just see Medicaid planning as the tip of the iceberg. The fundamental problem here is that—is not prosperous seniors taking advantage of Medicaid, or millionaires on Medicaid, as it is popular to portray in the media? The real problem is just regular folks are qualifying for Medicaid under the eligibility, which I will talk about in a minute, but I thought I would give you information on what was described to me as the average Medicaid planning client, in a study I did recently in Seattle.

The average client has a home worth \$250,000 to \$400,000 that they owned free and clear. They have got \$150,000 to \$200,000 in additional liquid assets, and \$2,000 to \$2,500 a month in income. Now, I don't think any of us would call that rich or wealthy, but it is the straw that can break the camel's back of Medicaid when we expand the social safety net to include folks at that level. But the fundamental problem with Medicaid is that the average person, in terms of income and assets, walks right on. There is no limit on how much income you can have, as long as your medical expenses, including nursing home care, are high enough. All you really need is a cash-flow problem, and that is critical, because there is no limit on how much you can have in assets, as long as you hold

them in the exempt form, such as a home and all contiguous property, a business, including the capital and cash-flow, home furnishings, exempt cars, prepaid burials, you could go on and on, and I have in many number of reports.

I would like to change now over to who gets hurt by the current system? Well, most of all, it is poor people. They don't have the key money that Medicaid planners advise their well-to-do clients to retain in order to get into the nicest facilities. Poor people don't have key money, so they are the ones that end up in the less attractive Medicaid facilities, and they don't get the home and community-based services that Medicaid has such difficulty providing.

The general public gets hurt, because they have anesthetized to the risk of long-term care, as Dr. Burgess said. Nursing homes and other long-term care providers get the short end of the stick here, because of the notoriously low long-term care reimbursements through Medicaid. I don't have to tell you legislators are getting caught in the vise. Insurers and reverse mortgage lenders have no market for their product because people can ignore the risk, avoid the premiums, wait until they get sick, and the government will pay.

Mr. DEAL. Mr. Moses, would you summarize for us.

Mr. MOSES. I certainly shall.

Mr. DEAL. Okay.

Mr. MOSES. I just wanted to finish by saying what needs to be done. We have to stop using Medicaid as inheritance insurance for the baby boom generation. We have been pumping that anesthesia into the system for 40 years, and it has been very successful in putting people to sleep about this risk. We need to target Medicaid to the genuinely needy, and encourage everyone else with positive and negative incentives to either—to plan early and save, invest, or insure. This isn't complicated. Our problems with Medicaid and long-term care are caused by well-intentioned but perversely counter-productive public policy. If we stop doing what we have always done, we will get a different result, and that is very definition of sanity.

Thank you.

[The prepared statement of Stephen A. Moses follows:]

PREPARED STATEMENT OF STEPHEN A. MOSES, PRESIDENT, CENTER FOR LONG-TERM CARE FINANCING

Mr. Chairman and members of the Committee: thank you for inviting me to speak with you about the critical subjects of Medicaid and long-term care financing.

My brief remarks today are fully developed and documented in reports published on our website at www.centerltc.org.

If the question is "Who should pay for long-term care?", the average person will answer "Anybody but me." Denial is commonplace.

Next best, people say "Everyone should pay." Hence, we see a tendency to pass the financing burden on to government.

Finally, if nothing else works, most people will prepare to pay their own way. That's when they turn to private savings, investments, home equity or insurance.

Winston Churchill said "You can trust the Americans to do the right thing, but only after they've tried everything else first."

So, let's ask: What have we tried already in long-term care financing? That is, who does pay for long-term care and what have been the consequences?

Answer: the vast majority of all formal long-term care services are financed by government.

Although Medicaid pays only half the dollars for nursing home care, it covers two-thirds of nursing home residents and touches nearly 80 percent of all patient days with its notoriously low reimbursement rates.

Even the so-called "out-of-pocket" expenditures for nursing home care—which are down from 39 percent to 25 percent in the past 15 years—come mostly from Social Security benefits that Medicaid recipients have to contribute toward their cost of care.

At 13 percent, Medicare is a much larger payer for nursing home care than most people realize.

For home care, only 18 percent of the costs are paid by patients. The rest comes primarily from Medicare and Medicaid.

Now, what has this heavy dependency on public financing of long-term care achieved?

We have a severely dysfunctional, welfare-financed, nursing-home-based long-term care system that serves no one well, least of all the poor.

Long-term care today is plagued by institutional bias, too little home and community-based care, bankruptcies, inadequate revenue, a dearth of capital, staff shortages, access and quality problems, huge tort liability, unaffordable liability insurance, too few full-pay private payers and too many low-pay Medicaid recipients.

How in the world did we get into such a mess?

In 1965, Medicaid came along and started paying for nursing home care.

The nursing home industry saw a huge new source of revenue and naturally built more facilities as fast as they could raise the walls.

The public figured nursing home care was free, so why pay out of pocket for home care or insurance?

That's how institutional bias began and that's why a market for home care, assisted living and long-term care insurance did not begin to develop until decades later.

Before long, of course, Medicaid nursing home costs exploded.

Figuring, "they can't charge us for a bed that doesn't exist," government capped the supply of nursing home beds by requiring certificates of need (CONs).

But capping supply only drove up the price as nursing homes raised their rates to compensate. So Medicaid capped what it would pay for nursing home care.

In turn, nursing homes raised rates for private payers to make up the difference. That was the origin of "cost shifting" from Medicaid to private payers.

Over time, Medicaid nursing home census grew and private pay census declined, as fewer people could afford the higher private pay rates and Medicaid eligibility became easier and easier to obtain.

A new practice of law—Medicaid estate planning—evolved to impoverish people artificially so they could qualify for Medicaid without spending down.

But the average person in terms of income and assets could qualify for Medicaid even without such legal machinations because of the program's generous eligibility criteria.

With supply and price capped and eligibility easier and easier to obtain, nursing homes could fill their beds by accepting Medicaid's low rates almost without regard to the quality of care they offered.

Thus arose the access and quality problems that led to heavy government regulation of nursing facilities.

Today, nursing homes are caught between the rock of inadequate reimbursement and the hard place of quality regulation.

Or, as I've heard industry executives express it: "the government expects Ritz Carlton care for Motel 6 rates while imposing a regulatory Jihad."

In the meantime, both Medicaid and Medicare have played a growing role in financing home care, which most people prefer, but which those programs cannot afford.

The result is that the public has been anesthetized to the risk of long-term care even as state and federal coffers have been emptied by government's efforts to help.

It's the same old story: good intentions led to unforeseen consequences.

That brings us to the most important question to ask: who WILL pay for long-term care in the future?

Certainly not government. That well is dry. No one is so naive anymore as to expect a new publicly financed long-term care system to come along.

More and more, the hard reality is true: if you want access to quality long-term care at home or in the community, you must be able to pay privately for it.

As publicly financed long-term care continues to deteriorate, more and more people will turn to their home equity as the only way to pay for acceptable care.

Eighty percent of seniors own their homes and 73 percent of those own them free and clear. Nearly \$2 trillion is available and easily accessible through home equity conversion, while still allowing borrowers to retain the use of their homes.

When the only choice becomes "inadequate welfare-financed long-term care or spend down your home equity to get quality care," more people will turn sooner to private insurance as a viable alternative.

With more people insured and paying privately at market rates, care choices and quality will improve for everyone, rich and poor alike.

With fewer people dependent on Medicaid, the welfare program will be better able to provide a wider range of higher quality care to the genuinely needy.

We will get to that point by default simply by staying on the current course, but many people will be hurt.

Or, we can remove the perverse incentives in public policy that currently trap people on Medicaid.

The single most important step to take is to stop using Medicaid as inheritance insurance for the baby boom generation.

We need to tighten eligibility, require spend down of illiquid home equity as a condition of eligibility, and enforce estate recovery requirements.

When the choice is "pay me now or pay me later," as in the old Fram oil filter commercial, most people will save, invest or insure for long-term care and everyone will be better off.

Thank you for your attention. I'll try to answer any questions you may have.

Mr. DEAL. Thank you. Well, we made it a little over halfway through the panel before we had to go vote again. If you will excuse us again, we are going to go vote, but we will be back shortly. We will stand in recess, pending these votes.

[Brief recess.]

Mr. DEAL. We have been given permission to go ahead without anyone else. They will be here. They will be coming in. I apologize to you. Mr. Krooks pointed out to me that you don't have a timer down there. We normally have a timer that lets you know when you have a minute left. I apologize for that. And I know it would be rude to turn over your shoulder and look at the clock, which I am looking at, which is behind you there. So I will try to maybe give you the high sign when you are close to the time limit. Mr. Krooks, we will start with you.

STATEMENT OF BERNARD A. KROOKS

Mr. KROOKS. Thank you, Mr. Chairman. I just want to point out that in addition to being here as a practicing attorney with the firm Littman Krooks, I am also here as a past President of the National Academy of Elder Law Attorneys, which is a national not for profit association, which provides information, education, networking, and assistance to lawyers, bar associations, and others, who deal with legal services to the elderly and people with special needs. And I want to thank you for the opportunity to testify before you today.

Let me just start out by saying that the problem is the United States does not have a comprehensive system for long-term care. We discriminate in our delivery of healthcare based on the type of illness one has. If you have an illness like heart disease or cancer, the United States provides comprehensive care through Medicare. If you have a chronic illness, like Parkinson's disease, ALS, otherwise known as Lou Gehrig's disease, Alzheimer's disease, or multiple sclerosis, the government doesn't help you unless you impoverish yourself and then first qualify for Medicaid.

Most families needing long-term care feel defeated by having to apply for a welfare program after years of working and saving.

Many are children of the Great Depression, and are World War II veterans. Many are women, who after losing their husbands to the devastation of a chronic illness have to suffer the indignity of impoverishment and financial dependence on family or government. The bottom line is that our healthcare system penalizes people who have pursued the American dream, who have saved for retirement, and then get the wrong disease.

Clients don't come to me seeking Medicaid. That is a myth. Medicaid is the payer of last resort. People want the best quality of care for a loved one. They want to receive care at home, as we have heard numerous times today. They want to avoid impoverishing the community spouse. They want to avoid losing the family home. Providing a legacy for children or grandchildren is low on the list. Seniors engage in long-term care planning mainly because they find themselves in a lose-lose situation. First, they lose their health and need long-term care, and then, they come face to face with nursing home costs that average over \$70,000 annually. Second, they learn that they will have to lose virtually their entire estate to pay for this long-term care.

Another myth is that millionaires are going on Medicaid. The fact is millionaires cannot and are not on Medicaid. They cannot go on Medicaid. They don't need Medicaid. Most can afford the much-preferred home care, even on a 24 hour basis. In fact, many would face potentially large capital gains and gift taxes if they were to transfer their assets. Moreover, seniors are just not comfortable giving up control of their assets. Transferring assets and impoverishing themselves is not something they want to do. When a client comes to see me, and the client has significant assets, I suggest they consider seeing a professional who is able to provide information regarding their long-term care insurance options.

Proposals have been put on the table that will make Medicaid asset transfer penalties more punitive, and will mainly hurt seniors who act in good faith, yet fall innocently into the budget cutting process. One proposal to make penalties harsher calls for changing the start of the penalty period from the date of transfer to the date one applies for Medicaid. This has the practical effect of extending the penalty period for years beyond what it is now.

A few of the likely victims of such measures include a grandparent caring for a grandchild who provides savings to help pay for the grandchild's education, a devoted church supporter who devotes substantial time to his church and donates personal assets to the church, the widow who lacks records of her now-deceased husband's spending, the caring sister who uses savings to help a needy sister remain at home. Under the proposals to tighten transfer of asset rules, each of these individuals would be cutoff Medicaid if they subsequently get sick and need long-term care.

I would like to give you a couple of examples of how the new proposals would work if enacted. There are many more examples contained in my written testimony. Let us take the case of Mr. Banks. Mr. Banks is living independently, and has a pretty active life, although he does suffer from diabetes and heart disease. He sold his house, his only asset, for \$135,000, and he donated 10 percent of the proceeds to his local charity. Mr. Banks moved to assisted living, and thereafter, his condition deteriorated, and he had to go to

a nursing home. Two years later, Mr. Banks had spent his entire savings on the cost of his care, did not make any transfers, and he would otherwise be eligible for Medicaid, but for this \$13,500 gift, the 10 percent of the \$135,000 house that he sold, that he made 2 years ago. Under the new proposal, the penalty period attributable to that gift would not start until he applied for Medicaid 2 years later. Under current law, the penalty would have long expired.

Let me give you another example, again, so you can see how these new rules work, if they were enacted. Let us take the case of a mother who helps her two children. Her daughter has medical problems, and does not have insurance, and her son's daughter, her grandchild, is in college with expensive tuition. So she helps her daughter by paying \$30,000 for healthcare. She is uninsured. And she helps her granddaughter by paying \$50,000 in tuition. These are significant amounts paid almost 5 years before she was forced to go into a nursing home. With a 5-year lookback, which is proposed under the administration's budget, and a penalty period starting on the day of application, she will be ineligible for nursing home care for more than 17 months. Now, that number fluctuates depending upon the State regional divisor, but seniors will not be able to help out family members, because they will not be able to predict their future. This is a case where 5 years earlier, she helped out a grandchild with college education expenses and with healthcare expenses for a daughter, and then she is penalized for a year and a half when she goes into a nursing home 5 years later. These are just a couple of the many examples, and the types of people who will be hurt under these proposals.

Mr. Chairman, I thank you for the opportunity to present testimony to this distinguished panel that has done so much for the elderly and individuals with disabilities over the years. As you can see from my remarks, one's life can truly end up on a Wheel of Fortune or misfortune. You spin the wheel, and if it lands on heart disease or cancer, your costs are covered. If it lands on Lou Gehrig's disease, multiple sclerosis, or Alzheimer's disease, you are on your own. If you get the right illness, the government will pay. If you get the wrong illness, they will not. Unfortunately, none of us has any control over which illnesses we contract.

I would be happy to respond to any questions you may have. Thank you.

[The prepared statement of Bernard A. Krooks follows:]

PREPARED STATEMENT OF BERNARD A. KROOKS, PAST PRESIDENT, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS

Good morning. Chairman Deal and Ranking Minority Member Brown, I congratulate you on calling this hearing. I appreciate the opportunity to testify as a professional serving the elderly and individuals with disabilities and as a past president of the National Academy of Elder Law Attorneys (NAELA). Thank you for your openness to our experiences and ideas as you consider the complex issues of long-term care and Medicaid.

The National Academy of Elder Law Attorneys is a national, non-profit association composed of more than 4800 attorneys. NAELA provides information, education, networking, and assistance to lawyers, bar organizations, and others who deal with the many specialized issues involved with legal services to the elderly and people with special needs.

Elder Law

My professional practice is devoted to assisting seniors and others with disabilities. Elder law is a specialized area of law that involves representing, counseling, and assisting elderly and individuals with disabilities and their families in connection with a variety of legal issues. It is a holistic approach to the practice of law that focuses on the individual rather than a particular area of law. I have included at the end of my statement a list of the areas in which elder law attorneys provide support to older and disabled persons. I hope that it gives you a good picture of the range of concerns we help our clients work through, such as wills, advance directives, trusts, guardianships, government benefits, and long-term care insurance.

The Long-Term Care System

Mr. Chairman, as I am sure you know, unpaid caregivers provide the majority of long-term care in the United States. Researchers estimate the value of this unpaid caregiving at well over \$196 billion per year.¹ By contrast, paid caregiving costs the public and private sectors about \$173 billion,² more than a quarter of which is paid out-of-pocket by individuals and their families. Nursing home care costs approximately \$70,000 per year on average, with 36% of that paid out-of-pocket by individuals and their families. It is in this context that families needing long-term care services engage in financial planning to pay for those services.

The United States does not have a national health insurance program and it does not have a comprehensive long-term care system. Based on the experiences of NAEJA's members with thousands of older clients and clients with disabilities, we support a national long-term care system that would provide comprehensive services, including home and community-based and institutional services, to people with serious physical and cognitive impairments. However, until a comprehensive long-term care system for all Americans is in place, it is essential for Medicaid to continue its role as a federal-state program and continue to help pay for the long-term care needs of low and middle-income older individuals and individuals with disabilities.

When the Medicare bill was signed into law, President Johnson was clear about our commitment to protect older Americans. He said:

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime, so that they might enjoy dignity in their later years. No longer will young families see their own incomes and their own hopes, eaten way simply because they are carrying out their deep moral obligations to their parents.

Unfortunately, this goal of Medicare remains unfulfilled for many Americans with chronic illnesses. If someone is acutely ill, there is a chance that he or she could get better. For example, someone with heart disease could have bypass surgery and be fully recovered. However, if someone has a chronic illness, there is no reasonable expectation of recovery. For example, someone who has Alzheimer's disease can never fully recover. As we know, Alzheimer's disease can be a long journey for the victim as well as the caregivers and other family members. A person can survive a decade or more before ultimately succumbing to the ravages of this disease.

We discriminate in our delivery of health care based on the type of illness one has. If you have an illness like heart disease or cancer, the United States provides comprehensive care through Medicare. If you have a chronic illness like Alzheimer's disease, Parkinson's, ALS (Lou Gehrig's disease), or Multiple Sclerosis, the government doesn't help unless you impoverish yourself first and qualify for Medicaid.

Most families needing long-term care feel defeated by having to apply for a "welfare" program after years of working and saving. A colleague of mine from Illinois recently stated that most middle-income seniors who turn to Medicaid for nursing home care are "people who are up against a wall because of a serious illness, who have never depended on a government handout in their lives." Many are children of the Great Depression and are World War II veterans, our so-called "greatest generation." Most of them are women, who, after losing their husbands to the devastation of chronic illness, have to suffer the indignity of impoverishment and financial dependence on family or the government.

The bottom line is that our health care system penalizes people who have pursued the American dream, saved for retirement, and then get the wrong disease.

¹ Peter S. Arno et al., "The Economic Value of Informal Caregiving," 18 *Health Affairs* 182 (March/April 1999) (estimates for 1997);

² Health Policy Institute, Georgetown University, Long-Term Care Financing Project, *Fact Sheet: Who Pays for Long-Term Care?* (May 2003), available at: <http://ltc.georgetown.edu/pdfs/whopays.pdf>, accessed July 31, 2003.

What I Do—Who Comes to Me and Why

When I do long-term care planning it is a part of a larger planning process that:

- Examines the full range of long-term care options, issues and costs relevant to the client's circumstances;
- Pursues the goals of preserving and promoting the individual's dignity, self determination, and quality of life; and
- Respects the individual's fundamental values and preferences as defined by the client.

It is a rare day when I spend most of my time counseling clients well in advance of the long-term care crisis. Most often, the lawyer's help is sought when the need for long-term care has already arrived. It usually involves spouses and children of persons needing nursing home care who have already been heavily invested in providing care to the person for an extended period.

My clients' goals, in order of priority, typically consist of:

- Finding the best quality of health care for their loved one
- Supplementing the Medicaid personal needs allowance (typically \$30 to \$50 per month in most states);
- Paying for non-covered Medicaid services and needs (e.g., dental care, hearing aides, eyeglasses, private duty nurse, clothing, books, flowers, etc.);
- If a couple, ensuring the financial security of the community spouse (CS);
- Avoiding burdening the family;
- Avoiding losing one's home (Medicaid liens and recover); and
- Providing a modest legacy for the children (while the estate tax is being eliminated for well-off families, states are ramping up Medicaid estate recovery—the estate tax on the disabled).

Mr. Chairman, please keep in mind that when people do become eligible for Medicaid, regardless of whether they have engaged in long-term care planning, they must pay all but a small portion of their income each month for their care. Medicaid then pays whatever the difference is between that amount and the Medicaid rate. Thus, costs to Medicaid are always mitigated by the Medicaid recipient's monthly income.

In some cases, married couples are faced with having to consider divorce when one spouse requires long-term care in a nursing home, or else face financial ruin. Clients are emotionally devastated by the necessity to make the decision to go this route at a time when they are most vulnerable. For a society that professes to support the institution of marriage, this is a sad and desperate situation.

Who Doesn't Come to Me for Help with Medicaid and Why

Millionaires do not go on Medicaid. They don't need Medicaid. Most can afford the much-preferred home care, even on a 24-hour basis. Most would face potentially large capital gains taxes, loss of step-up basis, and gift taxes if they engaged in transfer strategies. Those with retirement plans often face significant taxes if they liquidate the plan prior to death. Tax planning is usually antithetical to Medicaid planning.

Rather, millionaires have other options available to them—including long-term care insurance and tax planning. They have no need to rely on Medicaid, nor would they want to. Medicaid is a valuable program, but there are many disadvantages to relying on Medicaid—such as limitations in access to health care providers, limitations in coverage, exposure to recovery against one's estate after death, and state-by-state variations in eligibility and coverage.

No one yearns to be on a program like Medicaid. It is rare for a senior to come in to my office and say "I want to give away my money so I can go on Medicaid." Seniors engage in long-term care planning mainly because they find themselves in a "lose-lose" situation. First, they lose their health and need long-term care and come face to face with nursing home costs now averaging approximately \$70,000 per year. Second, they learn that they will have to lose virtually their entire estate to pay for long-term care —paying 100% out-of-pocket until they reach Medicaid's definition of impoverishment.

Medicaid Proposed Changes—Punitive or Positive?

Over the years, the Congress has enacted provisions to balance the welfare entitlement focus of the Medicaid program with the reality that middle-income Americans have few other options for long-term care. The transfer of asset rules are well designed for accomplishing a balance between the needs of individuals and families with that of fiscal responsibility. The transfer of asset rules include such provisions as:

- Individuals must postpone Medicaid eligibility if they give away assets;

- Only gifts from the recent past (3 years) are looked at, because they are the most likely to have been done with any thought of Medicaid eligibility;
- The penalty starts when the individual gave the money away because that is when the individual would have had it and could have used it for his or her care;
- Transfers of certain assets and transfers to certain individuals are protected from penalties because public policy should not promote or foster homelessness or financial dependency on the government by those whose loved ones need Medicaid; and
- Estate recovery exists so that states can be reimbursed for the monies they have spent to care for the individual on Medicaid in a nursing home.

This debate should also acknowledge the significant financial crisis faced by a couple when one requires long-term care. For example, by enacting the Medicare Catastrophic Coverage Act of 1988, amended in 1989, we have adopted a national public policy to provide a modest degree of financial security to the spouse of an individual who requires long-term care. Through this policy, we have enabled the spouses of individuals who require long-term care services to continue their relationship rather than be forced to choose between poverty and divorce. This will change with the proposals Congress is presently considering.

Making asset transfer penalties more punitive will mainly hurt seniors who act in good faith yet fall innocently into the State budget cutting process. One proposal to make penalties harsher calls for changing the start of the penalty period from the date of transfers to the date one applies for Medicaid. This has the practical effect of extending the penalty period for years beyond what it is now. A few of the likely victims of such measures are: the grandparent caring for a grandchild who provides savings to help pay for the grandchild's education; the devoted church supporter who donates personal assets to the church; the widow who lacks records of her now deceased husband's spending; the caring sister who uses savings to help a needy sister remain in her home. Under the proposals to close transfer of asset rules, each of these individuals will be cut off Medicaid if they subsequently get sick and need long-term care.

What Will Happen if You Change the Start Date of the Penalty Period?

Medicaid: Penalty Rule Computation

I. Current Law Concerning Penalty for Asset Transfers of Less than Fair Market Value:

The penalty period commences on the first day of the month following the month in which the transfer was made or the first day of the month in which the transfer is made, at the state's option.

II. Proposed Legislation:

Under the President's Proposed Budget, the penalty period would commence on the date of the transfer or the first day of the month during or after which a Medicaid application has been made, whichever is later.

III. Analysis and Issues

1. Under this proposal, seniors and people with disabilities denied Medicaid would, at the time of the denial, be impoverished, have physical and/or mental impairments so severe they could no longer care for themselves, be in need of nursing home or home care, and have no other means (private insurance or Medicare) of paying for care.
2. The denial of long-term care will trigger adverse medical consequences. The absence of skilled nursing, physical, occupational and speech therapy and necessary assistance with medical care and activities of daily living will adversely affect seniors and people with disabilities who will be denied home care and nursing home admission under this proposal.
3. The harsh penalty that would be created by this proposal would be applied to all those who are unable to immediately recover the funds or the value of property alleged to have been improperly transferred prior to the Medicaid application. Most transferees will have no legal obligation to refund the transfer. In other cases, transferees will be financially unable to make any refund or there will be no transferee from whom to recover. For example, a senior with Alzheimer's who made a \$3,000 withdrawal from her savings account thirty six (36) months prior to the Medicaid application would be ineligible for Medicaid long term care benefits for a portion of the month in which she applies. The nursing home or hospital will not be paid for care provided.
4. This proposal would discourage donations to charities, religious and political organizations and candidates for government office. Only those who can predict with

- absolute certainty that they will not need Medicaid for at least three years could safely make donations.
5. This proposal will harm families by inhibiting older members from providing financial assistance to younger members—with such things as down payments on homes and college tuition—out of fear that they may not qualify for Medicaid nursing home care if unforeseen events leave them unable to care for themselves.
 6. In addition to the harm to seniors and those with disabilities, there would be considerable financial harm to health care providers. Hospitals and nursing homes are prohibited from discharging patients unless suitable alternative arrangements can be made, even if it means providing extended uncompensated care.
 7. In cases where the nursing home admission has already occurred and the penalty is applied, nursing homes will be required to provide uncompensated care for the duration of the penalty period or until hospitalization. Nursing homes would become financially strapped—influencing staffing levels and the quality of care for all residents.
 8. Those in hospitals at the time of the denial would be unable to leave since nursing homes and home care agencies will deny admission if there is no source of payment. Hospitals will become the default providers of care as access to nursing homes is barred during the penalty period. The cost of hospital care to the government will be far higher than it would have been in long-term care.
 9. This proposal will most likely not harm those who set out to “game the system” because they most likely will be able to learn how to circumvent it, while those who have no such intent will likely learn of the policy long after it is too late. In fact, this proposal may encourage more and earlier transfers, while it is unclear how this proposal encourages the purchase of long term care insurance, especially because some of those people are uninsurable.
 10. Most long-term care is provided by informal caregivers (e.g. family members). This change could also have far-reaching economic effects if a family member has to leave his or her job to try to take care of a severely incapacitated elder.

What Will Happen if You Extend the Lookback Period?

Medicaid: Lookback Period

I. Current Law Concerning the Medicaid Lookback Period

Federal law (42U.S.C 1396p(c)) requires states to withhold payment for various long-term care services for individuals who dispose of assets for less than fair market value. The term assets includes both resources and income. The lookback period for both institutional care and home and community based waiver services is 36 months, except the lookback period for trust-related transfers is currently 60 months.

II. Proposed Legislation to Extend the Medicaid Lookback Period to Five Years

The budget bill may include a proposal to change the lookback period to 60 months for institutional care and home care, regardless of whether there have been trust-related transfers.

III. Analysis and Issues

1. The proposal will create unacceptable new obstacles for vulnerable, frail elderly individuals and persons with disabilities to get care, because the proposal will require record keeping and documentation that is far beyond the normal practices of the elderly, especially poor and chronically ill elders. Therefore, low-income elders would be denied admission to a nursing home because of inadequate record keeping.
2. Medicaid recipients who already receive home care services under the current law could lose eligibility under the proposed changes if they had made transfers within the past five years. Services could be abruptly terminated; thereby placing the elderly individual at risk of serious harm and inadequate or inappropriate care in the community.
3. The harshest impact of this proposal will be on those applicants with dementia, who will not be able to provide documentation or recollection for transfers, regardless of how small.
4. The extension of the lookback period is arbitrary and without sound reasoning, other than to look for transfers in order to keep seniors from accessing Medicaid for nursing home care (while increasing administrative costs). The current federal law uses three years, which is a sufficient and reasonable time period to assume that any transfers made were not in contemplation of a future event. The average stay in a nursing home is less than three years. Hence, under current law, most seniors with more significant assets who transfer assets at the

- onset of needing long-term care in a nursing home will not receive Medicaid reimbursed nursing home care.
5. Any increase in the lookback period will have a significant impact on administrative overhead and be more burdensome on frail elderly, who must search and obtain records of proof for older transactions. How will the frail elderly (especially those with dementia) do this from a nursing home bed?
 6. The proposal suggests that the elderly can predict their medical and financial circumstances five years into the future. An extended lookback coupled with a change in the transfer rules will punish unwitting elders who have helped their families with commonly made gifts and then experience medical events such as a stroke, hip fracture or Alzheimer's disease.
 7. There is no reliable data to support the proposition that a longer lookback period will reduce the Medicaid program's share of nursing home care costs.

Examples of How the Proposed Legislation Will Affect the Elderly

Mr. Chairman, I have provided for the Subcommittee's consideration "typical examples" of how these proposals will hurt real Americans and their families.

1. A church supporter

Mr. Banks was living independently and actively in Florida though he suffered from diabetes and heart disease. He sold his home for \$135,000 and donated 10% of the proceeds, or \$13,500, to his local church. Mr. Banks moved to assisted living and thereafter to a skilled nursing facility. Two years later, Mr. Banks had exhausted his funds and would otherwise be eligible for Medicaid but for this \$13,500 gift to his church. Instead, Mr. Banks is ineligible for assistance for four months and has no resources to pay for his care during that period. Under existing law, Mr. Banks would have been penalized when he made the \$13,500 gift and that penalty period would have elapsed long before his need for public assistance arose.

2. A grandparent caregiver

Mr. and Mrs. Brown are the primary caregivers for their 16-year-old grandchild. Over the last three years they have paid \$20,000 for support of their grandchild. Mr. Brown suffers a stroke and needs long term care. Mrs. Brown has total liquid assets of \$50,000. Mr. Brown is *otherwise eligible* but will not be approved for Medicaid because of the \$20,000 expenditure for his grandchild. Instead, Mrs. Brown will be placed in the precarious position of paying privately for six months that will, at today's costs, totally exhaust her \$50,000 nest egg.

3. A family emergency

Mrs. Jones' daughter loses her job due to chronic fatigue syndrome. The daughter is a single parent with two underage children. Mrs. Jones helps her daughter financially in amounts totaling \$30,000. Six months later, Mrs. Jones suffers a heart attack and a debilitating stroke requiring long-term care. Two years later an impoverished Mrs. Jones applies for Medicaid and is denied because of the \$30,000 gift made several years earlier.

4. Cash-based couple

Mr. and Mrs. Smith live in their own home and pay most of their day-to-day expenses with cash. Mr. Smith generally withdraws about \$500 per month for food, gas, newspapers, house wares, car repairs, etc. Generally, he does not keep receipts, at least not in any organized way. Mrs. Smith has never handled their financial affairs and suffers from mild dementia. Unexpectedly, Mr. Smith suffers a stroke and now needs nursing home care. Their current assets and income would make him eligible for Medicaid coverage without difficulty under current law.

His withdrawals of \$500 per month will result in a penalty period, unless they are accounted for. His withdrawals add up to \$6000 per year in potentially disqualifying transfers, or \$18,000 for the three-year lookback. Since Mrs. Smith cannot document the use of the withdrawn money, Mr. Smith will face a penalty period of approximately 4 months. ($\$18,000 \div \$4,500/\text{mo}$ (average regional nursing home rate) = 4 month).

7. A helper through hard times

Mr. T, age 80, has been ill for several years since a stroke. His wife, age 75, has been caring for him at home. He became more seriously impaired this past summer when he contracted pneumonia. He was walking with assistance before the pneumonia, but increasing weakness has left him unable to walk. She is continuing to care for him at home, but nursing home placement looks imminent.

Mrs. T has a son from a previous marriage who lives in another state and is not well off. During the last half of 2001, Mrs. T paid his mortgage for him, at \$850

per month (\$5,100 total). In May of 2002, she gave him \$2,200 to help him purchase an automobile so he could commute to and from a new job.

Thus, her total transfers were \$7,300. Their own savings are now dwindling. Her husband will be otherwise eligible for Medicaid, but under the waiver proposal, he will face a penalty period of one month and some days. Mrs. T will have to find a way to pay this out of pocket.

8. A caring sister

Two sisters, both in their 80s, have lived with each other in an apartment for several years. Both have reasonably sufficient assets to cover their anticipated needs. However, one sister has considerably more assets (about \$250,000). She is concerned that if she were to become ill and leave the apartment to move into a nursing home, the sister with fewer assets would not be able to afford to remain in the apartment.

The sister with greater assets wishes to take steps to ensure that her sister will be able to continue living in the apartment, if possible, and so she funds an irrevocable trust with \$48,000, intended to supplement the poorer sister's costs of living if the need arises.

Under current law and a regional monthly transfer rate of \$4500, this transfer will result in a disqualifying period of a little over ten months ($\$48,000 \div \$4500/\text{mo} = 10.67 \text{ months}$) from the date of transfer. But under the proposal, the caring sister, after spending down all her assets on nursing home care, would then face a penalty period of more than ten months before receiving Medicaid nursing home coverage. Alternatively, if she is aware of the penalty rules, she may be reluctant to help her less fortunate sister in the first place.

9. Helping family

A mother helps her two children—her daughter has medical problems and does not have insurance and her son's daughter (her grandchild) is in a college with expensive tuition. So she helps her daughter by paying \$30,000 for health care and she helps her granddaughter by paying \$50,000 in tuition. These are significant amounts paid almost five years before she was forced to go into a nursing home. With a five year lookback and a penalty period starting on the day of application, she will be ineligible for nursing home care for more than 17 months (depending upon the state's regional monthly transfer rate). Seniors will not be able to help family members because they will not be able to predict their circumstances.

10. A widow lacking records

Mrs. Waters was married for fifty years. Prior to his death, Mr. Waters handled all financial transactions. Mrs. Waters suffers from dementia and upon Mr. Waters' death is placed in a skilled nursing facility. Her resources are expended and she is applying for Medicaid. She has no knowledge or ability to explain the cash withdrawals totaling \$50,000 during the five years preceding her husband's death. Nonetheless, Mrs. Waters is ineligible for Medicaid due to these inexplicable transfers.

11. A mother helping her daughter

Mr. and Mrs. G are in their late seventies and retired. Two and a half years ago, they were living independently and relatively healthy. At that point, one of their daughter's marriage ended and the daughter moved closer to her parents to be near them. She was unemployed at the time and needed to work. Her parents bought her a modest car for \$18,000 so that she had transportation to get back and forth to work. The daughter then started working in a series of part-time jobs, which provided her just enough to meet her living expenses.

Two years after giving their daughter the car, Mr. G suffered a major stroke. He lost his ability to speak, walk and use his left arm. He received rehabilitation following the stroke but did not recover all of his abilities. Despite medical advice, his wife insisted on bringing him home. She cared for him herself and paid for services privately for one year. At that point, Mr. G's needs had increased and Mrs. G had become considerably weakened due to the demands of being the primary caregiver. They reluctantly decided that he would be best cared for in a skilled care facility. Mrs. G paid privately for this care for one year. By then, her assets were depleted and she had no more than the amount that would be protected for her as a community spouse. She applied for Medicaid benefits on behalf of her husband and was denied benefits due to the purchase of the car for their daughter.

Long-Term Care Insurance

Mr. Chairman, when a client comes to see me with significant resources, I suggest that they consider seeing a professional who is able to provide information on their long-term care insurance options. Congress and the Administration have for a number of years considered modifying the current laws regarding long-term care insur-

ance. NAE LA has consistently supported legislation that couples tax credits for long-term care caregivers with tax deductions for the premiums paid on the purchase of long-term care insurance. We believe this would be a positive way to assist caregivers and those that are willing, able, and qualify to purchase insurance.

I frequently advise clients with sufficient assets to consider long-term care insurance. Elder law attorneys may be the single largest supporter of long-term care insurance as a serious option, with the exception of the insurance industry itself. In many cases, however, our clients cannot afford the products or do not meet the underwriting criteria and will not be able to buy it. Nonetheless, I refer many clients to long-term care insurance agents if they have the resources and might be approved for coverage.

Some have wrongly claimed that the proposed changes to the asset rules will expand the use of long-term care insurance. NAE LA does not believe this is true. However, NAE LA strongly believes that long-term care insurance has a vital and appropriate role in helping to provide long-term care to some Americans and that we should continue to explore ways to make it a useful tool for more of us.

NAE LA and I also support the expansion of the Long-Term Care Insurance Partnership Program. I am aware that a number of Members of Congress and consumer groups have reservations about doing this, but I believe it is time to look carefully at this program and make any changes that are needed to make it a viable alternative in all states. The President has included this in his budget proposal and we believe your committee should help move this forward this year.

Other Medicaid Budget Cuts

Some believe that the solution to Medicaid's increasing costs lies in methods either to limit federal funding and/or offer states greater flexibility in the administration of the program. I do not believe either will succeed. Capped funding or a block grant approach may offer states short-term fiscal relief but result in long term financial disaster for them. Modification on a state-by-state basis of fundamental eligibility rules will destroy what uniformity the program does have and shred the safety net that we need so desperately for all of Medicaid's beneficiaries.

Neither a limitation of federal funding nor a restriction in Medicaid's fundamental eligibility rules will change the fact that seniors and individuals with disabilities, their spouses and their families will continue to require basic health care. I hope this Congress does not allow a frail and vulnerable senior to suffer at home without treatment because we have restricted services or rewritten categorical eligibility rules that eliminate the senior from participation. Further, the Administration proposed that changing the Medicaid asset rules would save \$4.5 billion. There is no research that supports this assumption. In fact, the limited research data available reveals that there is little to be gained by changing these rules and much harm to be done to the elderly and individuals with disabilities.

Assuming that we have not become a society that turns its back on those in need, then these proposals accomplish nothing more than a shift of costs for the care that we should provide to those who are at risk. If federal funding for such services is limited, and the services continue, who will pay? At some level, whether by state, county, hospital, nursing home or private individual, the level of uncompensated care will increase. When that burden is borne by each state, hospital or nursing home, then the financial viability of each payer will be weakened further and the integrity of our health care system will be compromised.

NAE LA supports the efforts of Senators Smith and Bingaman and Representative Heather Wilson and many others who have worked to create a bipartisan Medicaid Commission that would take a thoughtful look at this critically important program and work to find innovative solutions to its problems. Please let good policy drive your actions, not the budget.

Conclusion

Mr. Chairman, I thank you for the opportunity to present testimony to this distinguished panel that has done so much for the elderly and individuals with disabilities over the years. As you can see from my remarks, one's life can truly end up on a Wheel of Fortune or misfortune. You spin the wheel and if it lands on heart disease or cancer, your costs are covered; if it lands on Lou Gehrig's disease, Multiple Sclerosis or Alzheimer's disease, you are on your own. If you get the right disease, the government will pay; if you get the wrong disease, they will not. Unfortunately, none of us has control over which illnesses we contract.

I ask that even in these times of tight budgets that you continue the commitment that you have made to care for millions of Americans through the Medicaid program.

Mr. Chairman and Members of the Subcommittee, I would be happy to respond to any questions you may have. Thank you.

NAELA Members as Resources: Issue List

The National Academy of Elder Law Attorneys' (NAELA) has members that are valuable public policy and substantive law resources. Within the membership we have expertise in almost all federal, state and local programs serving or affecting the elderly. Many are willing to be supportive of the work of legislators and regulators, and will provide expert opinions, testimony, articles, and other written materials upon request. Issue areas include, but are not limited to: Alternative Dispute Resolution; Disability Law; Estate Planning; Health Care Decision Making and End of Life Issues; Health Care Advanced Directives; Long-Term Care Planning; Long-Term Care Insurance; Managed Care; Medicare; Medicare Appeals; Medicaid; Mental Capacity Issues; Nursing Home Care, Law, and Litigation; Public Interest Representation (including Legal Services Corporation and Older Americans Act delivery systems); Retirement Housing; Retirement Planning; Guardianships, Conservatorships and other Surrogate Decision Making processes; Social Security; Supplemental Security Income; Tax Planning; and Trusts and Wills.

Mr. DEAL. Thank you. Dr. Stucki.

STATEMENT OF BARBARA R. STUCKI

Ms. STUCKI. Good afternoon. My name is Barbara Stucki. Over the past 12 years, I have been conducting research on private sector financing for long-term care. I currently manage the Use Your Home to Stay at Home Initiative for the National Council on the Aging. Thank you for the opportunity to testify about the potential of using home equity to help balance public and private funding for long-term care, and to respond to seniors' preference to age in place in their own homes.

NCOA recently completed a study, funded by CMS and the Robert Wood Johnson Foundation, which provides compelling evidence that reverse mortgages could significantly increase the funds available to pay for home and community-based long-term care. We found that 82 percent of current seniors own their own homes and have more than \$2 trillion in untapped housing wealth.

Policy discussions on long-term care financing have largely ignored home equity as a source of private financing for in-home services and supports. This, in part, is because many retirees cannot get a conventional mortgage or home equity loan, because they lack sufficient income to make monthly loan payments. The recent development of reverse mortgages offers a new way for them to use their home to stay at home.

Reverse mortgages are a special type of loan that allows people aged 62 and older to convert home equity into cash while they continue to live at home. The money borrowers receive is tax-free. Unlike conventional mortgages, there are no income requirements. Reverse mortgages, I should say borrowers, do not need to make any loan payments for as long as they live in their home. An important protection is that borrowers or their heirs will never owe more than the value of the home at the time they sell it or repay the loan.

NCOA estimates that almost half of households aged 62 and older, that is 13.2 million households, are candidates for using a reverse mortgage to pay for long-term care at home. Our analysis shows that these loans could increase private sector funding for in-home services and supports by \$953 billion. Reverse mortgages can also reduce dependence on Medicaid by lowering the risk of spend-down, saving Medicaid \$3.3 to \$5 billion annually in 2010, depend-

ing on market penetration rates. These savings are based on our estimates that about 5 million older households are at financial risk for needing Medicaid, and could obtain up to \$308 billion from reverse mortgages. The funds available from these loans could be a powerful mechanism for allowing seniors to maintain their dignity and independence. Tapping home equity can also give seniors who have not been able to plan ahead through conventional means new options to pay for help at home.

Greater awareness of the potential of reverse mortgages will help make this product a mainstream option for long-term care financing. Government, nonprofit organizations, and industry should work together to develop educational campaigns targeting consumers, service providers in the community, and senior advisors.

There are a number of things Congress can do to promote the use of reverse mortgages. For example, a provision in the American Home Ownership and Economic Opportunity Act of 2000 waives the upfront mortgage insurance premium for a reverse mortgage, but only when this loan is used entirely and exclusively to purchase private long-term care insurance. This limitation makes the provision unworkable. It should be changed to waive the premium for borrowers who use a reverse mortgage primarily to pay directly for long-term services and supports. Congress is also likely this year to consider making Medicaid long-term care public-private partnership programs more available in many States. A similar approach should be used to promote the use of reverse mortgages. States should also develop incentives to help frail seniors who cannot get help under Medicaid home and community-based waivers, because they have not yet met the nursing home level of care criteria. Reverse mortgages could pay for earlier interventions to reduce nursing home placement.

Our written statement summarizes eight other policy proposals not related directly to reverse mortgages, for giving States more flexibility and improving access to Medicaid home and community services. I want to point out that NCOA opposes mandatory use of reverse mortgages. We believe that government incentives will increase demand for these types of loans while still preserving consumer choices and autonomy.

In conclusion, policymakers should provide incentives for leveraging the literally hundreds of billions of dollars in untapped housing assets by promoting reverse mortgages as part of a public-private effort to help fund services for aging in place. With additional education, policy changes, and consumer protections, this strategy can open new possibilities for a more balanced approach to long-term care financing. This approach can reduce the risk of institutionalization, save Medicaid dollars, and enhance the quality of life for older Americans.

Thank you.

[The prepared statement of Barbara R. Stucki follows:]

PREPARED STATEMENT OF BARBARA R. STUCKI, PROJECT MANAGER, USE YOUR HOME TO STAY AT HOME INITIATIVE, NATIONAL COUNCIL ON THE AGING

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Barbara Stucki. Over the past 12 years, I have been conducting research on private sector financing for long-term care. I currently manage the Use Your Home to Stay at Home Initiative for the National Council on the Aging (NCOA). I would like to

thank you for providing the NCOA the opportunity to testify about the potential of using home equity to help better balance public and private funding for long-term care and to respond more rapidly to consumer preferences for “aging in place.”

As the population ages and the pressure on state Medicaid budgets rises, it becomes increasingly important to find effective ways to improve our long-term care financing system. Funding the growing demand for long-term care is a—major national challenge. The NCOA has recently completed a new study, funded by CMS and the Robert Wood Johnson Foundation, that provides compelling evidence that reverse mortgages could significantly increase the funds available to pay for home and community-based long-term care.

With appropriate incentives, additional educational efforts and strong consumer protections, we believe that millions of older homeowners could benefit from using these loans to continue to live at home. Voluntary use of reverse mortgages could pay for many years of home and community services, and help postpone the need for assistance from Medicaid.

REVERSE MORTGAGES—A NEW FINANCING OPTION FOR AGING IN PLACE

Most older Americans would prefer to “age in place” in their own homes. The high proportion of long-term care paid by government, however, suggests that few seniors can afford to pay these costs for very long. One of the paradoxes of our current long-term care system is that impaired older Americans are struggling to live at home at a time when they own more than \$2 trillion in untapped housing wealth. Home ownership is high among seniors (82%), even among the those at advanced ages (75 and older—78%). Many have accumulated substantial amounts of home equity, including families whose other retirement resources may be very modest. Over half the net worth of seniors is currently illiquid in their homes and other real estate.

Policy discussions on long-term care financing have largely ignored home equity as a potential source of private financing for in-home services and supports. This situation arose, in part, because older homeowners have had few options to liquidate housing wealth. Many retirees cannot get a conventional mortgage or home equity loan because they do not have enough income to make monthly loan payments. The development of reverse mortgages in the last 15 years offers a new way for older Americans to “use their home to stay at home” by tapping a portion of their home equity.

In the United States, reverse mortgages are the principal financial instruments available to seniors who want to convert some of their home equity into cash. Reverse mortgages can give older homeowners the funds they need to pay for long-term care and other expenses, while allowing them to continue living in their own homes. These types of loans are called “reverse” mortgages because the lender makes payments to the homeowner. Since the loan is based on the equity in the home, lenders do not consider the borrower’s income, or credit and medical history in determining eligibility for a reverse mortgage. The Department of Housing and Urban Development (HUD) Home Equity Conversion Mortgage (HECM) program is the oldest and most popular reverse mortgage product. Currently, HECMs represent about 90 percent of all the reverse mortgages in the market.

The amount that a homeowner can borrow is based primarily on the age of the youngest homeowner, the value of the home, and the current interest rate. Older owners (because of their limited life expectancy) and those with more expensive homes are able to get higher loan amounts. Borrowers can select to receive payments as a lump sum, line of credit, fixed monthly payment (for up to life), or a combination of payment options. Proceeds from a reverse mortgage are tax-free, and borrowers can use these funds for any purpose. Reverse mortgage borrowers do not need to make any payments for as long as they (or in the case of couples, the last living borrower) continue to live in the home as their primary residence. When the last borrower permanently moves or dies, the loan becomes due.

There are several key protections in place for people who decide to take out a reverse mortgage. All reverse mortgages are non-recourse loans, which mean that the borrower or heirs never owe more than the value of the home at the time of sale or repayment of the loan. All borrowers who apply for any reverse mortgage must first receive independent counseling before they complete the loan application. In addition, Federal Truth-in-Lending law requires that reverse mortgage lenders disclose the projected average annual cost of the loan. Borrowers can cancel the loan for any reason within three business days after closing. To protect impaired older homeowners, additional standards may be required. Since these loans can be used for any purpose, there are currently no formal standards used by the mortgage industry when marketing this product.

By using a reverse mortgage to liquidate a portion of their housing wealth, seniors do not have to move or relinquish control over their most important asset. Since reverse mortgages only allow borrowers to tap a portion of their home equity, there may be funds left over after paying off the loan to support the spouse or cover assisted living or other facility care. Borrowers or their heirs can also benefit from any appreciation in the value of the home over time. Spouses are protected since they will never owe more than the value of their home.

EXPANDING FINANCING FOR AGING IN PLACE

Greater focus on home equity can add an important new element to the long-term care financing debate. Based on our analysis of the 2000 Health and Retirement Study, NCOA estimates that almost half of households age 62 and older—13.2 million—are candidates for using a reverse mortgage to pay for long-term care at home (defined as being able to receive a minimum of \$20,000 from this loan). The amount of funds that could become available if these older homeowners liquidated a portion of their home equity is substantial. By calculating the amount of funds that could be available from reverse mortgages for individual households, we estimate that these loans could increase private sector funding for in-home services and supports in total by \$953 billion.

Target populations—Reverse mortgages could play an important role in reducing the likelihood that older Americans will deplete their financial resources paying for long-term care. This could be especially important to older households with moderate incomes whose resources, while adequate for daily needs, are inadequate to handle more than a few years of home care payments (averaging about \$27,000 per year in 2000). This group is often referred to as “tweener.”

The NCOA study estimates that among candidate households for a reverse mortgage, there are about 3.3 million households who are at financial risk for spending-down if they need home care (Table 1—Spend-down risk). These moderate-income elders could tap almost \$63,000 on average with a reverse mortgage. Most of these households (66 percent) consist of unmarried homeowners.

Table 1. Distribution of home ownership by market segment

	Total households age 62+	Total owner households	% total households	Candidate households for using a RM for LTC	% total households	% owner households
Medicaid beneficiary	2,537,000	1,058,000	41.7%	437,000	17.2%	41.3%
High risk Medicaid	4,444,000	2,927,000	65.9%	1,403,000	31.6%	47.9%
Spend-down risk	7,331,000	5,449,000	74.3%	3,321,000	45.3%	60.9%
Low Medicaid risk	13,083,000	11,642,000	89.0%	8,034,000	61.4%	69.0%
Total	27,397,000	21,077,000		13,196,000		

Source: NCOA calculations based on data from the 2000 Health and Retirement Study.

About 0.4 million candidate households are Medicaid beneficiaries. On average, these homeowners who live in the community could receive a HECM loan worth \$51,229. At current interest rates, these funds would enable them to make monthly withdrawals of \$1,465 from a HECM creditline for about three years, or monthly withdrawals of about \$470 for ten years (Table 2). Only about one in three of these candidate households are married. Though Medicaid beneficiaries may be receiving home and community services, additional cash from reverse mortgages can help cover unmet needs while providing greater choice and control over services.

High Medicaid risk households have very limited income and assets. These financially vulnerable elders could access a lump sum or line of credit worth on average \$55,085 from a HECM loan (Table 2). With limited financial resources, they would quickly qualify for public assistance if they needed long-term care. Since the home is a protected asset under Medicaid eligibility rules, the motivation to access home equity among this group is likely to be small. However, a reverse mortgage could be very important to support family caregiving, since most (69 percent) homeowners in this group are married. These loans could also help this group of elders avoid institutionalization. These older homeowners may not be able to afford an assisted living facility, and there are long waiting lists for HCBS waivers and subsidized housing.

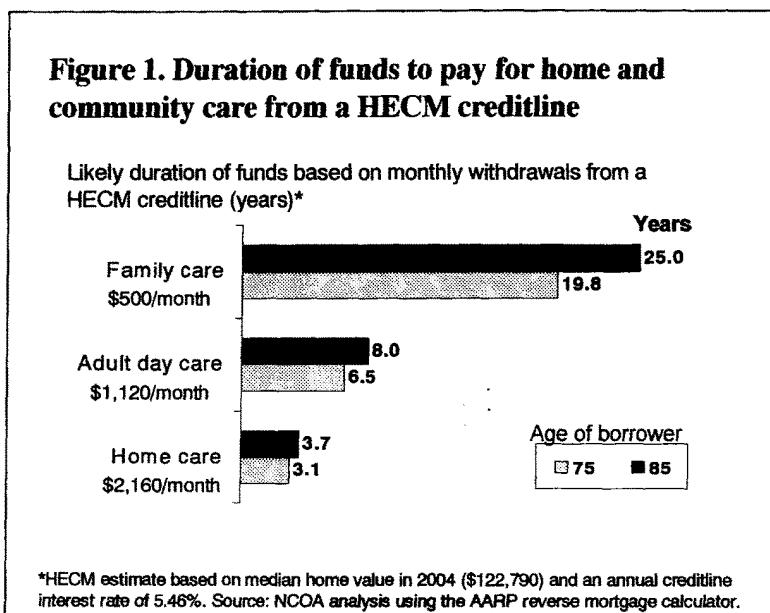
Table 2. Amount of potential HECM funds, by Medicaid risk level

	Average potential cash or creditline from a HECM loan	Monthly withdrawals by estimated duration of funds		
		3 years	5 years	10 years
Medicaid beneficiary	\$51,229	\$1,465	\$895	\$470
High risk Medicaid	\$55,085	\$1,575	\$964	\$506
Spend-down risk	\$62,800	\$1,798	\$1,100	\$577
Low Medicaid risk	\$80,130	\$2,290	\$1,403	\$737
Total	\$72,128			

NCOA calculation using the AARP reverse mortgage calculator and a creditline interest rate of 4.35%.

Low Medicaid risk households include homeowners who can afford to pay for daily home care for at least two years (single households) or four years (married households). The average reverse mortgage loan value among this group is \$80,130. With greater access to liquid assets, more affluent elders might be reluctant to tap home equity to pay directly for in-home services and supports. Demand for reverse mortgages among this group may instead emerge from a desire to protect their wealth and leverage their resources through private long-term insurance. About half (53 percent) of Low Medicaid risk households consist of couples.

Potential savings to Medicaid—For many middle-income seniors on fixed incomes, a reverse mortgage can be a critical resource to help avoid a financial crisis. This loan could pay for over three years of daily home care visits or eight years of adult day care for a homeowner age 85 with a median priced home (Figure 1).



Payments from a reverse mortgage can help reduce dependence on Medicaid and reduce the risk of institutionalization. Increased use of this financial option for long-term care could result in savings to Medicaid ranging from about \$3.3 to almost \$5 billion annually in 2010, depending on market penetration rates increasing from 4 percent to 25 percent of older homeowners. This represents 6 to 9 percent of the total projected annual Medicaid expenditures, including nursing home care. These reductions result from the additional income available to borrowers that would delay eligibility for Medicaid. When contrasted with the amount Medicaid is expected to spend on seniors for long-term care services at home in 2010 (\$14.9 billion, based on estimates by the Congressional Budget Office), \$3.3 to \$5 billion in reverse mortgage funds could be a substantial additional resource for people who need assistance to age in place.

Rebalancing the System

Many states and communities are developing creative ways to support older people who want to age in place. The impetus for these efforts reflects the convergence of two important goals: meeting consumers' desire to stay at home while controlling the rising cost of long-term care. Despite local and national efforts to promote aging in place, however, the pace of change has been slow. Reverse mortgages could provide an immediate source of funds to stimulate and enhance government efforts to rebalance our country's long-term care system toward increased access to home and community services.

For many older Americans, the home is their most valuable asset. Many are reluctant to touch this resource until their other financial resources and family caregivers are exhausted. This strategy can increase the risk that seniors will not have enough money to maintain their independence or the home they cherish. When they reach a crisis point, older homeowners often tap home equity by selling the home. Housing wealth, however, can be more than just a last resort. Reverse mortgages can pay for preventive measures such as home modifications, expenses of family caregivers, as well as day-to-day support that can reduce the risk of institutionalization.

Reverse mortgages can also strengthen existing financial plans by filling in gaps (such as the cost of replacing a furnace) and help impaired elders manage cash flow to cope with the uncertainties that often come with a chronic health condition. Tapping home equity can give seniors who have not been able to plan ahead through conventional means (such as long-term care insurance) new options for maintaining independence and choice if they need help at home. These loans give seniors more flexibility in managing their financial assets over time.

Reverse mortgages hold considerable promise to help impaired, older homeowners pay for the services they need to continue to live at home. Using home equity to pay for long-term care insurance is more problematic. Based on our analysis, this approach will likely be an option for only a very small number of older homeowners. It can be very costly for borrowers since they would be paying both insurance premiums and interest on the loan for many years. In addition, borrowers who use the proceeds of their loan to pay their premiums face the risk of their coverage lapsing if they run out of loan funds before they need care. An alternate approach would be to use the loan proceeds to increase the amount of home and community care that homeowners fund out-of-pocket. This could make private insurance more affordable because elders could buy more limited long-term care insurance coverage. Current policyholders could also use a reverse mortgage for additional funds to avoid lapsing their existing coverage.

Need for Government Action

Additional cash from reverse mortgages offer impaired elders the flexibility and choice that can enhance aging with independence and dignity. This financing option should appeal to a greater number of older Americans and can encourage increased personal responsibility. But the strong feelings that today's seniors have about their homes suggest that this approach will not be a quick or easy solution to our nation's long-term care financing problem. Few older homeowners are currently interested in using a reverse mortgage due to a reluctance to use home equity and a lack of understanding about how these loans work. Without additional education and strong incentives to support family decisions regarding the use of home equity, the actual number of older homeowners who take out a loan to pay for help at home is likely to be small.

Impaired, older homeowners need additional information to evaluate the appropriateness of taking out a reverse mortgage. Consumer outreach can help older homeowners and their families understand the benefits and limitations of using a reverse mortgage to "age in place." Greater awareness of the potential of reverse mortgages will help seniors and the people who advise them consider this product as a mainstream option for long-term care financing.

Government, non-profit organizations, and industry could work together to develop educational campaigns targeting consumers, service providers in the community, and senior advisors. The state and federal governments should also include the use of reverse mortgages in their educational efforts on long-term care. The NCOA study found that adult children are far more comfortable with the idea of using home equity than their parents. Conversations about reverse mortgages could serve as an important catalyst to help families plan for their long-term care needs. A broad public education campaign would be of enormous value.

There are a number of other things Congress and CMS can do to address several consumer concerns that currently limit the use of home equity.

1. Remove government barriers that hinder access to reverse mortgages. Since reverse mortgages must be in first lien position, state use of Medicaid liens can be a deterrent to promoting home equity to pay for long-term care. Fannie Mae requires that any outstanding liens against the property must be paid in full at the loan closing. If a state places a lien on a home when one spouse goes on Medicaid, the community spouse will not be eligible to apply for a reverse mortgage. CMS should clarify Medicaid rules to ensure that Medicaid liens will be released if the surviving spouse wants to sell or refinance the property, or obtain a reverse mortgage.

2. Increase the funds available from home equity by reducing reverse mortgage loan costs. In 2000, Rep. LaFalce included a provision in the American Homeownership and Economic Opportunity Act to amend Section 255 of the National Housing Act to waive the up front mortgage insurance premium (usually 2 percent) for a reverse mortgage used to purchase private long-term care insurance. While we support the intent of the law, which was to make reverse mortgages more available for long-term care needs, it unduly limits consumers' options by requiring participants to use the *entire payment exclusively* for insurance. A far more desirable and appropriate use would be for long-term services themselves. Congress should amend or repeal the provision and instead waive the premium for borrowers who use a reverse mortgage primarily to pay for such services and supports. The law could also be expanded to waive the premium for borrowers independently assessed to need long-term care.

3. Stretch loan funds to promote aging in place for as long as possible. The Center for Medicare and Medicaid Services (CMS) could enable Medicaid beneficiaries to use funds from a reverse mortgage to purchase non-covered home- and community-based services. Other alternatives include developing Medicaid buy-in programs with home equity or enabling states to target older homeowners at risk for Medicaid.

CMS could allow states to experiment with programs that target seniors who are ineligible to qualify for home and community services under a Medicaid waiver program because they have not yet met the nursing home level of care criteria. Incentives could be developed to use home equity to pay for earlier interventions that support aging in place and reduce the risk of institutionalization.

4. Reduce the risk of impoverishment and protect the spouse. Congress is likely this year to consider making long-term care "public-private partnership" programs more available to consumers in many states. Four states—California, Connecticut, Indiana and New York—now use this approach to promote the purchase of long-term care insurance by protecting purchasers' resources from the Medicaid eligibility asset test. A similar approach should be used to promote the use of reverse mortgages. Borrowers who use a certain portion of the equity in their homes to pay for long-term care could receive more favorable treatment under Medicaid's resource rules.

Government incentives for reverse mortgages may encourage impaired seniors to access home equity sooner and reduce the need to recoup public long-term care expenses through estate recovery. Many of the consumer concerns that motivate the use of Medicaid estate planning, such as loss of control of assets and a desire to leave a bequest, can be addressed through reverse mortgages. By providing cash, these loans enable impaired seniors to control the type and amount of services they receive. Since a reverse mortgage only taps a portion of home equity, it is possible that there will be funds left for heirs after the loan is paid.

Use of Reverse Mortgages Must be Voluntary

In developing a roadmap for the future, it will be important to ensure that the desire for government savings is balanced with the need to expand the ability of seniors to continue to live at home. As we look to the future, it will be important to find ways to improve the functioning of the reverse mortgage market in such a way that both consumers and government benefit.

NCOA opposes mandatory use of reverse mortgages. We believe that government incentives will increase demand for these types of loans while still preserving consumer choice and autonomy. Incentivizing the use of reverse mortgages also offers a better way to respond to rising demand and fiscal constraints. Offering incentives to increase the use of home equity could open new avenues for public and private resources to complement one another in meeting the changing needs of impaired seniors who live at home.

Other Medicaid Reforms

There are a wide variety of other Medicaid long-term care reforms that would promote greater independence, dignity and choice, while reducing per capita costs. For example, NCOA supports:

- The President's "Money Follows the Person" rebalancing proposal. Under the proposal, for persons transitioning out of institutions, the federal government would cover the entire first year of costs for Medicaid home and community-based waiver services in select states;
- Permitting states to provide Medicaid home and community-based services (HCBS) under a state plan amendment, rather than having to go through an often burdensome waiver process;
- Giving states more flexibility by eliminating the current requirement that Medicaid HCBS coverage be linked with a need for nursing home level of care;
- Recognizing under the Medicaid eligibility asset test that persons in need of HCBS must pay for housing, food, clothing, utilities, and transportation, while nursing home residents do not incur these costs;
- Leveling the playing field on protections for spouses since, under current law, spousal impoverishment protections are mandatory for nursing facility services, optional for HCBS waiver programs, and prohibited under the Medicaid personal care program;
- Permitting states to include Medicare savings in their Medicaid HCBS waiver budget neutrality calculations;
- Reducing barriers for states to provide consumers with greater opportunities to choose consumer directed models of Medicaid home and community services, such as cash and counseling; and
- Permitting Medicaid recipients in need of long-term care to receive community attendant services as an alternative to institutional care.

In summary, funding the growing demand for long-term care is a—major national challenge. Policymakers should leverage limited housing assets by promoting reverse mortgages as part of a public-private effort to help fund services for aging in place. With additional education and strong consumer protections, this strategy can open new possibilities for a more coordinated financial approach that can reduce the risk of institutionalization and enhance quality of life for older Americans.

Mr. DEAL. Thank you. Ms. Hansen.

STATEMENT OF JENNIE CHIN HANSEN

Ms. HANSEN. Thank you, Mr. Chairman and Mr. Brown. Can you hear me now? Yes, I hear myself. All right. Thank you, Mr. Chairman and members of the subcommittee who are here. My name is Jennie Chin Hansen. I am a member of the Board of Directors of AARP, and I appreciate the opportunity to testify.

I will be testifying primarily on the area of reverse mortgages, as well as long-term care insurance, and also, the partnership program, but as an aside comment, part of my past 25 years actually has been involved with a program that integrated acute and long-term care. I was the direct—the organization of On Lok Senior Health Services just a few months ago, and certainly, many of the comments of looking at the issues of community-based care is really fundamental to really the founding of our organization. So we really do, as AARP, and certainly, in my previous role as head of the prototype for the National Pace Program, really support this whole effort right now on moving toward community-based care.

But the issue at stake today is really about Medicaid, and I think so much has already been said, to acknowledge that with Medicaid and long-term care, there really isn't an effective system that has been designed, and especially since it was designed as a program close to 40 years ago, that was institutionally based. Ironically, the fact that nursing homes were actually considered the alternative at that time to help families, and so here we have a pendulum swing

at this time to make sure that we do have services moving in the other direction.

But right now, with the fundamental issue that we have is often-times the need for both discussion and debate on how to provide Americans with further alternative options for financing long-term care, just so that they don't have to rely on Medicare, excuse me, Medicaid alone, and then how to make sure that we will preserve and strengthen the program of Medicaid as a health insurance safety net.

We well understand and appreciate the immediate concerns of the Governors and Congress, as we have been hearing today, about the challenges of financing Medicaid, both now and in the future. There are policy changes that can make Medicaid more effective, but these changes should be driven by sound policy, and not just the arbitrary budget target.

However, we do recognize the need for some immediate changes in the Medicaid program, but we don't think that that should overshadow the longer range debate about transforming our system of long-term care, of which many speakers have spoken in a similar manner. Today, I have been asked to speak about three options for financing long-term care, reverse mortgages, long-term care insurance, and the long-term care partnership program.

You have heard a great deal earlier from the expertise of Dr. Stucki about the interest on reverse mortgages, but we wanted to address this as AARP, that this could play an important role as one answer to helping in the financing of long-term care. The chief advantages that we see of reverse mortgages are that there are no income limits or requirements, as Dr. Stucki has said, and then, especially, that there are no required monthly payments. But a huge downside is the considerable high cost associated with instituting a reverse mortgage. The total upfront cost of this could affect a typical borrower at the rate of \$16,500 per transaction.

So there have been changes, some that have been enacted, and some proposed, that would make reverse mortgages less attractive to consumers. In the year 2000, Congress waived the upfront mortgage premium for individuals who get a reverse mortgage through HECM, but only if the available equity is used to buy long-term care insurance, as was stated.

Tying the purchase of long-term care insurance to a reverse mortgage is expensive for the consumer, and not necessarily the best way to finance needed services. The homeowner pays all the costs associated with the reverse mortgage, and plus the long-term care policy itself. The equity, needless to say, is tied up in insurance and not available to directly purchase preferred home and community-based services, or to actually do some work on their home to make it safer for them to be able to stay at home.

Some suggested really using the reverse mortgage in order to qualify for Medicaid. Unfortunately, this approach would expose a community spouse to a much greater risk of impoverishment, and in some cases, Medicaid could actually end up paying more to care for somebody who has had a reverse mortgage. Given the limited experiences most consumers have had with reverse mortgages, a logical way would be to test the use of these loans as a long-term financing option, is a possibility through a limited demonstration

program. These demos could be designed to reduce borrower cost, and I think Dr. Stucki offered that as an option, and this is what we realize is a key reason why people don't want to take out reverse mortgages. In fact, the current HECM program began initially as a research and development study that became a demonstration program, and eventually became, now, a permanent program.

So let me turn briefly to long-term care insurance, which has had a limited role in financing long-term care. Unfortunately, as you have heard, people don't buy long-term care policies for a wide variety of reasons, including costs, the market instability, denial that they need it, and other pressing financial issues that they may be facing.

We wanted to emphasize that consumer protections, as has been cited, is an important part of long-term care policies. The National Association of Insurance Commissioners has developed a long-term care insurance model act and regulations that States can adopt to provide standards for long-term care policies. Legislation introduced in previous Congresses include consumer protections for long-term care insurance, and this, AARP supports.

Finally, I have been asked to comment on the long-term care partnership program that allows individuals who buy long-term care insurance policies to protect a certain amount of their assets to become eligible for Medicaid. The program, as you have heard from both Dr. McClellan and many other speakers, is limited to four States, and only a small number of partnership programs right now have actually accessed Medicaid. It is not clear whether these persons using Medicaid would have likely spent down to Medicaid if they did not have a partnership program, and that was what Dr. Holtz-Eakin had said also.

Partnership programs may offer another option for financing long-term care, but several improvements really need to be made, as outlined in my written testimony. So, we know that Congress must begin to look for options that will allow for Americans to pay for the care that they need in the setting of their choice. Choice has been an operative word here.

AARP stands ready to work with members on both sides of the aisle, the administration, and all stakeholders, to really address this emerging and very important issue of long-term care facing our country.

Thank you very much.

[The prepared statement of Jennie Chin Hansen follows:]

PREPARED STATEMENT OF JENNIE CHIN HANSEN, AARP BOARD MEMBER

Mr. Chairman and members of the Subcommittee, I am Jennie Chin Hansen, a member of AARP's Board of Directors. Thank you for the opportunity to testify today.

Affordable long-term care is a critical issue for AARP members and their families. I learned this firsthand as the Executive Director of On Lok, Inc., a non-profit family of organizations that provide comprehensive primary, acute, and long-term care services to nearly 950 frail older persons and 5,000 other older adults in San Francisco.

AARP believes the time has come to reinvigorate a national debate over how to help Americans plan for and obtain the long-term care services they need in the most appropriate setting. To that end we commend the Subcommittee for holding this hearing. We hope that this is the first in a series of ongoing discussions.

THE NEED FOR AN AFFORDABLE SYSTEM OF LONG-TERM CARE

Americans are living longer than ever thanks to tremendous advances in medicine and public health, and this longevity brings the need for appropriate long-term care. The segment of our population age 85 and older—those most likely to need long-term care—is estimated to increase by over 2.6 million people (about 60 percent) between 2002 and 2020. Baby boomers are now nearing retirement, taking care of aging parents, and facing their own future long-term care needs. In the near future, more Americans in their 60s will be caring for people in their 80s and 90s. We hear from our members every day who are trying to do the right thing—balancing the demands of work and family and balancing their personal finances, while worrying about their future retirement income and how to pay for long-term care.

Unfortunately, aside from a handful of programs like On Lok, there is no comprehensive public system of long-term care available to most Americans and very few other long-term care financing options exist. Long-term care insurance is limited and generally expensive. According to America's Health Insurance Plans, in 2002, the average cost of a long-term care insurance policy with automatic inflation protection was \$1,134 per year when purchased at age 50 and \$2,346 per year if purchased at age 65.

Public programs are also limited. Medicare provides some home health and skilled care, but does not cover nursing home stays. Medicaid's income and asset limits require impoverishment. For those people who pay out-of-pocket for their care, the expense associated with years of care often outstrips personal savings. According to a recent MetLife Marketing Institute report in 2004, the average annual nursing home costs were over \$61,000 for a semi-private room and over \$70,000 for a private room. The average hourly rate for a home health aide in 2004 was \$18, so as little as 10 hours a week of home health care would average over \$9,000 per year.

Many Americans currently rely on informal caregivers for the bulk of long-term care services. According to a forthcoming analysis of data from the National Long-Term Care Survey for AARP, over 90 percent of persons age 65 and older with disabilities who receive help with daily activities are helped by unpaid informal caregivers. Two-thirds of those 65 years of age and older with disabilities who receive help with daily activities only receive informal unpaid help. But caregivers face many physical, emotional, and financial demands that often take a serious toll.

One of the fundamental issues at the heart of the current Medicaid debate is how to provide Americans and their families with alternative options for financing long-term care services while maintaining Medicaid as a critical safety net program for the millions of lower income Americans who rely on it for health care. The notion that middle and upper income Americans are clamoring to qualify for long-term care coverage through a poverty program is far from accurate. The problem is that there are few other options available.

We believe one way to change the paradigm is to create new choices that give consumers more control and allow older Americans and people with disabilities to age with dignity and independence in the setting of their choice. We also believe it is important that consideration of specific long-term care financing options be made in the context of this broader discussion, and not be driven by the current budget debate and a specific budget target.

As Congress begins to explore new financing options, we should look to the growing role that private financing is already playing to support people with disabilities and their families with the home-and community-based services that they prefer. Our members want greater control over the services they receive and the providers of those services. Policymakers, providers, and consumers should work together to bring about comprehensive changes in the way we finance and deliver care. At the same time, we must work to strengthen Medicaid to ensure that it provides choices and quality care to the persons who rely on the program.

Our testimony today focuses on three specific financing options for long-term care and the pros and cons of each: reverse mortgages, long-term care insurance, and the Long-Term Care Partnership Program.

REVERSE MORTGAGES

Because of the large and growing amount of home equity held by some older Americans, increased attention is being paid to the role this resource could play in financing long term care. Over the past decade, more homeowners have begun using their home equity as a means of paying for long-term care services. In some cases, they have done so by selling their homes and reassigning the proceeds to assisted living and continuing care retirement communities (CCRCs). Others have used home equity to retrofit their houses or to pay directly for home and community-

based services. Still others have chosen reverse mortgages for purposes other than long-term care.

There are two basic types of reverse mortgages: public sector reverse mortgages that must be used for a single purpose and private sector reverse mortgages that can be used for any purpose. Public programs are offered by some state and local governments, generally at a low cost, and with income requirements. Most of these programs are limited to paying for home repairs or property taxes, although Connecticut developed a program specifically for long-term care financing.

Private sector reverse mortgages include the Home Equity Conversion Mortgage Program (HECM) that is insured by the Department of Housing and Urban Development (HUD), as well as two smaller private programs. HECMs make up more than 90 percent of the private sector reverse mortgage market.

To qualify for a reverse mortgage, an individual must: be age 62 or over; occupy the home as a primary residence; have paid off the mortgage or have a mortgage balance that could be paid off with proceeds from the reverse mortgage at closing; undergo required counseling in the HECM program; and live in a home that meets minimum HUD property standards. According to a recent study, HECM borrowers tend to be older, female, racially and ethnically mixed, live alone, and have lower incomes.

The chief advantages of these loans are that there are no income limits or requirements, and there are no required monthly repayments. The amount of money available depends upon the: age of the youngest borrower; the value of the home; the median home value in the county; current interest rates and other loan costs; and the type of private sector loan. Money from the reverse mortgage can be paid to the borrower as a lump sum payment at closing, monthly payments, a line of credit, or a combination of these methods. Borrowers make no loan payments as long as they live in the house. The loans are paid back when the last living borrower dies, sells the house, or permanently moves away.

A considerable downside to reverse mortgages is the high costs associated with the loans. For example, the total upfront costs and deductions on a HECM loan for a typical borrower (75 years old and living in a home valued at \$230,000) is about \$16,500. This amount is nearly equal to the \$17,000 median income of HECM borrowers.

Another disadvantage is the small size of the private reverse mortgage market. Even though HUD indicates the market is growing, only about 139,000 HECM loans have been taken out since the program's inception in 1989. High costs are a key reason cited by prospective borrowers for deciding against a HECM.

REVERSE MORTGAGES ARE NOT ALWAYS THE ANSWER

In 2000, Congress included a provision in the American Homeownership and Economic Opportunity Act that waives the upfront mortgage insurance premium for individuals who get a reverse mortgage through HECM if all the available equity is used to buy long-term care insurance. Consumer organizations—including AARP—have objected to the required tie to an insurance purchase and, to date, HUD has not implemented the program.

Tying the purchase of long-term care insurance to a reverse mortgage is expensive for the consumer and not necessarily the best way to finance needed services. The homeowner pays all the costs associated with the reverse mortgage plus the premiums and cost-sharing for the long-term care insurance policy, and it is not required that consumers be informed of the total, combined cost. Over time, reverse mortgage costs can double or triple the total cost of purchasing long-term care insurance due to high upfront loan costs and the growing amount of interest charged on the loan. Homeowners who can afford long-term care insurance without borrowing would be unlikely to need to use a reverse mortgage for this purpose particularly if they know how much the loan would add to the total cost. If homeowners cannot afford to buy long-term care insurance, it would not be wise to use a reverse mortgage to purchase the insurance since the reverse mortgage only adds to the cost of the insurance.

Another issue is the lack of a requirement to disclose the risks related to long-term care insurance policy cancellation or lapses, HECM loan default, or Medicaid eligibility. For example, if an individual exhausts all available reverse mortgage funds for the long-term care insurance premiums and is no longer able to pay the premiums, the policy could be cancelled or lapse due to nonpayment. The insurance coverage would be lost; the borrower would owe substantial and growing debt on the home, and would no longer be able to pay for the cost of long-term care.

Finally, borrowers could only use the loan money for insurance policies and not to directly purchase home-and community-based services or for home modification

that may better meet their needs. Most older Americans want to remain in their homes and are looking for ways to get needed services there rather than be institutionalized. Use of reverse mortgages may be one means of financing long-term care, but consumers should not be required to use their equity to purchase an insurance policy. Rather, they should have the choice to use the equity for the appropriate services in the setting of their choice.

In addition, some are considering requiring the use of a reverse mortgage in order to qualify for Medicaid. AARP does not support such a proposal. A reverse mortgage requires that a significant portion of home equity is used to pay for the costs of the reverse mortgage, rather than paying directly for long-term care needs. In fact, according to a recent study by Mark Merlis, there could be cases under such a proposal in which Medicaid actually ends up spending more to care for someone with a reverse mortgage. This is because Medicaid can recoup more of the money it spends through estate recovery if none of the home's equity has already been consumed by the high upfront costs and growing interest charges on a reverse mortgage. With a prior reverse mortgage, Medicaid cannot recover home equity that has already been used to pay the high costs of the loan.

Requiring a reverse mortgage before Medicaid eligibility would be particularly burdensome for persons owning lower-valued homes. For example, a 62-year-old living in a \$50,000 home could qualify for a HECM reverse mortgage of just under \$29,000—but over \$10,000 of that amount would be needed for upfront loan costs and deductions, leaving the borrower with less than \$19,000 in available loan funds. Medicaid would be requiring this homeowner to obligate over \$10,000 of home equity in order to borrow less than \$19,000.

This proposal raises many other concerns including the fact that taking out a reverse mortgage to cover the nursing home costs of a spouse would expose a surviving community spouse to much greater risk of impoverishment.

OPPORTUNITIES TO TEST THE USE OF REVERSE MORTGAGES

Given the limited experience most consumers have with reverse mortgages, a logical way to test this approach is through a limited demonstration program. One approach is to look at two ways to reduce borrower costs: 1) with modest, one-time public subsidies and competition among private providers in the HECM program, or 2) by building on the experience of low-cost public sector reverse mortgage programs to develop public loans for long-term care. Either way, borrowers would be able to access their own home equity to pay for the lower-cost services they want instead of waiting for estate recovery and liens to reimburse Medicaid for the institutional care they want to avoid.

Demonstration programs would allow for the examination of how people could use reverse mortgages to pay for their long-term care needs, which segments of the population might best be served by using reverse mortgages, how reverse mortgages could help expand access to home-and community-based services, and how to give people more choice and control in how they receive long-term care services.

The public sector has experimented with reverse mortgages relating to long-term care. The HECM program also provides valuable experience that could be drawn on to establish a demonstration program to allow older homeowners with disabilities to remain in their homes longer by using reverse mortgages to pay for services that they need to remain independent. Reverse mortgages could pay for things like home health care, chore services, and home modification.

Demonstrations would create opportunities for the federal and state governments, the private sector, and consumer groups to work together to explore the potential of reverse mortgages to pay for long-term care. There is time to carry out demonstration programs to test new approaches, to bring down the cost of reverse mortgages, and to make sure we get the policy right.

LONG-TERM CARE INSURANCE

Relatively few older persons have private insurance that covers the cost of long-term care. Many common long-term care needs (e.g. bathing, dressing, and household chores) are not medical in nature, do not require highly skilled help and, therefore, are not generally covered by private health insurance policies or Medicare. Long-term care costs are significant. The average hourly rate for a home health aide in 2004 was \$18, so even just ten hours of home health care per week would cost over \$9,000 per year. Average annual nursing home costs were over \$61,000 for a semi-private room and over \$70,000 for a private room in 2004, according to a recent MetLife Mature Marketing Institute report.

The market for private long-term care insurance has grown in recent years, but its overall role is still limited. Currently long-term care insurance pays for only

about 11 percent of all long-term care costs. By the end of 2002, over 9.1 million long-term care insurance policies had been sold in the United States with about 6.4 million of these policies still remaining in force. Most policies sold today cover services in nursing homes, assisted living facilities, and in the home. Typically, policies reimburse the insured for long-term care expenses up to a fixed amount, such as \$100 or \$150 per day. To receive benefits, the insured must meet the policy's disability criteria. Nearly all policies define disability as either severe cognitive impairment or the need for help in performing at least two activities of daily living (such as bathing and dressing). Most policies sold are in the individual market.

The cost of long-term care policies varies dramatically depending on a number of factors. The consumer's age at the time of purchase, the amount of coverage, and other policy features affect the policy's cost. Insurance companies can increase premiums for entire classes of individuals, such as all policyholders age 75 and older, based on their experience in paying benefits. Older adults are more likely to have more long-term care needs and higher costs, thus higher premiums. Other factors that affect the policy's premium include the duration of benefits, the length of any waiting period before benefits are paid, the stringency of benefit triggers, whether policyholders can retain a partial benefit if they let their policy lapse for any reason, including inability to pay (nonforfeiture benefit), and whether the policy's benefits are adjusted for inflation. Individuals with federally qualified long-term care insurance policies can deduct their premiums from their taxes, up to a maximum limit, provided that the taxpayer itemizes deductions and has medical costs in excess of 7.5 percent of adjusted gross income.

There are several reasons why Americans have not purchased long-term care policies. Denial is an important factor—most of us do not want to think about needing long-term care assistance. About one-third of Medicare beneficiaries still believe that they can rely on Medicare for their long-term care. Cost is another critical factor. Younger individuals are often concerned with the immediate costs of monthly bills, as well as major items such as buying a home, putting children through college, and saving for retirement. People don't plan for long-term care needs that they don't know much about or think they will not have. People may also associate a long-term care insurance policy with institutionalization. Others may be leery of long-term care insurance due to large premium increases and market instability. In addition, some individuals are not able to qualify for long-term care insurance due to underwriting.

Consumer protections are an important part of long-term care insurance policies. Standards and protections for long-term care insurance policies could make them better products that consumers are more likely to buy. For example, an individual who buys a policy in his or her 60s may not need long-term care for over 20 years. Without inflation protection, the value of the insurance benefits can erode over time. A daily benefit of \$100 in coverage will not buy as much care in 2025 as it does today. Nonforfeiture protection allows a consumer who has paid premiums for a policy, but can no longer afford to pay premiums to still receive some benefits from the policy.

The National Association of Insurance Commissioners (NAIC) has developed a Long-Term Care Insurance Model Act and Regulations that states can adopt to provide standards for long-term care insurance policies sold in a state. NAIC standards include: inflation protection, nonforfeiture, required disclosures to consumers, minimum standards for home health and community care benefits, premium rate stabilization, and standards for what triggers benefits. While all states have adopted some of the NAIC provisions, only 21 states have adopted a critical provision on premium stability that protects consumers from unreasonable rate increases that could make their policies unaffordable.

Legislation introduced in previous Congresses by Representatives Nancy Johnson (R-CT) and Earl Pomeroy (D-ND) includes consumer protections mandated by the Health Insurance Portability and Accountability Act of 1996 and incorporates some of the consumer protections in the NAIC Model Act and Regulations. AARP supports the standards for long-term care insurance included in this legislation.

LONG-TERM CARE PARTNERSHIPS

A hybrid of the public/private approach to financing long-term care services is the Long-Term Care Partnership Program. Currently operating in four states (California, Connecticut, Indiana, and New York), the program allows individuals who buy long-term care insurance policies under the program to protect a certain amount of their assets and become eligible for Medicaid. People who purchase long-term care insurance policies under the Partnership are partially exempt from estate recovery under Medicaid, except for New York and Indiana which offer total asset

protection. A provision in the Omnibus Budget Reconciliation Act of 1993 limited this estate recovery exemption to these four states who had state plan amendments approved by May 14, 1993 (plus Iowa which has not implemented a Partnership program).

The goals of the Partnership include encouraging people to buy private long-term care insurance when they might not otherwise do so; saving money for Medicaid by delaying or preventing spend-down to Medicaid eligibility; reducing the incentive for individuals to transfer assets; and saving money for individuals by having them rely on insurance policies to cover long-term care costs that they would have paid otherwise.

According to recent evaluations of the program, about 181,600 insurance policies have been sold under the Partnership. About 149,300 are currently in force. Of the individuals who purchased policies, only about 2,200 persons (1.2 percent of Partnership purchasers) have used their long-term care insurance policies and only about 90 people have actually accessed Medicaid (0.5 percent of total purchasers). It is unclear whether these persons using Medicaid would have likely spent down to Medicaid absent their participation in the program. It is not clear whether the policies were purchased by people who otherwise would not have bought insurance, whether the Partnership policies are a substitute for other long-term care insurance policies, and whether participants would have used Medicaid regardless. Because Partnership policyholders tend to be younger than other long-term care policyholders, it may be hard to assess the full impact of the Partnership program on Medicaid. It is possible that not enough time has passed for many Partnership policyholders to have exhausted their long-term care insurance policy and become eligible for Medicaid.

The Partnership states use three different methods to determine the amount of assets that will be protected for program participants: a dollar-for-dollar model, a total assets model, and a hybrid model. California and Connecticut use the dollar-for-dollar model that protects \$1 in assets for every \$1 in benefits paid out by the Partnership policy. New York uses a total assets approach where all of an individual's assets are protected if the individual purchases a Partnership policy with a minimum benefit package defined by the state and exhausts all of its benefits. New York is considering expanding its model to include a hybrid model. Indiana uses a hybrid model in which the amount of asset protection depends on the value of the benefits exhausted. To qualify for total asset protection, participants must exhaust a policy that covers about 4.2 years of nursing home care. Any policy with a benefit value below this amount would provide dollar-for-dollar protection. Partnership participants in California, Connecticut, and Indiana who have qualified for Medicaid have protected a total of \$2.8 million in assets, according to recent studies.

According to a recent report by the Congressional Research Service on the program, the income and asset levels of Partnership program participants vary. Almost half of Partnership purchasers in California and Connecticut have assets of greater than \$350,000 and 60 percent of purchasers in Indiana also have assets greater than this level (all excluding the home). An average of 20 percent of purchasers in California and Connecticut has assets of less than \$100,000 (excluding the home). In New York, 13 percent have assets between \$50,000 and \$200,000. The dollar-for-dollar-model allows states to approve more affordable options for lower-income consumers, while total asset protection encourages states to approve policies that are higher in value and more attractive to people with higher incomes. A significant number of participants in California and Indiana, 58 percent and 43 percent respectively, have monthly incomes that exceed \$5,000. Yet more than half of purchasers in Connecticut (57 percent) have income less than \$2,500. In Indiana, 17 percent of purchasers had monthly income less than \$3,000, 34.5 percent had monthly income between \$3,000 and \$5,000, and 43 percent had income of greater than \$5,000.

Partnership programs may offer another option for financing long-term care but several improvements need to be made. These improvements include:

- Protecting the Medicaid safety net for low-income people who need long-term care. The Partnership may increase Medicaid long-term care expenditures if people with significant assets are able to access Medicaid more easily. If this occurs and states are unwilling or unable to spend more on Medicaid, additional beneficiaries could reduce the resources available to impoverished people who need care.
- Requiring stronger consumer protections, particularly nonforfeiture and inflation protection, premium stability, and clear disclosure of current income requirements for Medicaid benefits and the state's right to change those requirements. As discussed earlier, consumer protections are very important to long-term care policies. Partnership participants need to also be clear on the Medicaid income

requirement and that it is a requirement that they must meet for Medicaid eligibility after they have exhausted their long-term care policy.

- Guaranteeing the types of services (particularly home-and community-based services) that the state would provide to eligible Partnership policyholders under Medicaid. Most current Partnership policyholders will not need long-term care for many years. Without this protection they have no assurance that the services covered by Medicaid today will be covered in the future.
- Requiring that states monitor admissions to nursing homes to ensure that equal access is available to everyone on the waiting list, regardless of source of payments. Nursing homes should not be able to discriminate against residents based on who is paying for their care.

CONCLUSION

We can no longer afford to put the issue of long-term care financing on the back burner. Congress must begin to look for options that would allow Americans to pay for the care they need in the setting of their choice. We urge you to focus on the people behind the policy discussion of new financing options and budget implications—the faces of families struggling to help a grandparent with Alzheimer's or a parent with physical limitations, and the faces of older Americans interested in staying independent and in their own homes for as long as possible.

AARP looks forward to working with this Committee, Congress, the Administration, and all stakeholders to address the broad long-term care needs our country is facing. We stand ready to work with members on both sides of the aisle to begin to tackle this important challenge.

Mr. DEAL. Thank you. Dr. Feder.

STATEMENT OF JUDITH FEDER

Ms. FEDER. Thank you, Mr. Chairman, and stalwart members of the committee. I appreciate the opportunity to participate in this hearing on such a critical issue, and I am sure I share with many people involved in long-term care work that we are pleased to see long-term care financing on the policy agenda.

However, as I hear the discussion, both today and more broadly, about long-term care and future policy, I am concerned about some distortion in that discussion. We hear enormous enthusiasm for private resources and private insurance as the foundation for future public policy toward long-term care financing, including proposals even to invest public dollars in supporting the private insurance.

On the other hand, we hear enormous skepticism about and even denigration of the capacity and desirability of public programs to meet long-term care needs, including proposals that would withdraw extremely important financing for long-term care. Based on 30 years of research and experience, and a review of the evidence, I can tell you that that perspective has the issue exactly backwards.

Private resources, both in caring and in dollar and private long-term care insurance have important roles to play in future financing for long-term care, but if we are to promote equitable, affordable access to long-term care when people of all ages need it, greater investment in public programs, whether through Medicaid or new social insurance, is absolutely essential.

Let me elaborate. I want to begin by emphasizing the importance of insurance. Insurance is the mechanism that we use to spread the risk of unpredictable catastrophic events, rather than allowing the costs to fall so overwhelmingly on the minority who experience financial catastrophe. Long-term care, intensive long-term care, is one such catastrophic event. It is clearly unpredictable for the close

to 40 percent of the long-term care population who are under the age of 65, but it is also unpredictable for people at retirement age, 30 percent of whom are estimated to die without needing any long-term care, while 20 percent of them are estimated to need more than 5 years of care.

Reliance on savings to deal with a catastrophic risk leaves the burden concentrated on those who experience it, even if it is handled by cashing out houses, as we would do with reverse annuity mortgages. And even when people have housing assets, research studies call into question whether seniors should sacrifice so much housing value in interest costs and other payments to banks, and whether these bank finance loans are preferable, or more precisely, less costly to Medicaid than estate recovery, which is already a provision of current law.

Now, let me turn to the risk spreading through insurance. The next question I would ask is why is private insurance so limited a vehicle, and there are several reasons. It is not available to people who need long-term care now, and the problem is now, not just in the future. It is not priced to serve the younger population that is also at risk. It is not affordable to significant segments of the older population, both now and in the future, and I would remind us that the median household income of elderly Medicare beneficiaries is \$25,000. Its benefits are often limited in an effort to keep premiums more affordable, and its premiums may be unstable, leaving purchasers still at risk of substantial expenses even if they hold insurance. With appropriate standards or protections, private long-term care insurance may be fine for the better off population, but policies that would use taxpayer dollars to subsidize it represent misplaced priorities, and in my view, misplaced investment of those dollars.

First, partnerships which rely on Medicaid to subsidize a time-limited insurance benefit remain expensive to modest income people, may substitute for insurance that they would have bought on their own, and according—because of this, according to CBO, may cost rather than save Medicaid money. Second, tax credits for the purchase of long-term care insurance would clearly cost new taxpayer dollars, and would also be targeted to the better off older population who can take care of themselves. Third, and most distressing, proposals to cut back Medicaid to force people to purchase private long-term care insurance are simply unconscionable, and as CBO recognizes in discussing such proposals, would likely leave many people without any protection or access at all.

Evidence on actual behavior shows that it is not Medicaid limitations that are the primary barrier to—excuse me, Medicaid, that is the primary barrier to the purchase of long-term care insurance. Rather, it is many other factors, some of which I and others have discussed.

Now, the public role. Medicaid is our Nation's long-term care safety net. Its costs are high, not because it is serving the wrong population, but because serving the large numbers of people who need long-term care and cannot afford it is expensive. Remember, Medicaid is a public-private partnership. Beneficiaries give up virtually everything they have to receive Medicaid benefits. The argument that the bulk of Medicaid resources go to people who are able

to pay for their—on their own, and who transfer their assets is not supported by the evidence, and the evidence tells us that most elderly likely to need long-term care have too little income and assets to warrant transfer, especially if they are disabled. People in poor health are more likely to conserve their assets than to exhaust them. Among all the elderly, transfers that do occur are typically modest, less than \$2,000, and for those seeking Medicaid eligibility, they are not significant contributors to Medicaid costs, and the fact is that most elderly nursing home users pay most or all of their costs of the care.

Making Medicaid meaner is likely to save Medicaid little, and punishing modest income people unlucky enough to need long-term care before they die, while preserving the estates of the wealthiest Americans and everyone else is just plain unfair. Today's Medicaid provides not too much but too little protection, focusing on nursing homes, not home care, or more than home care. Eligibility and benefits vary tremendously across States, and as we have heard, States are struggling with today's fiscal burdens, let alone what they will have to deal with in the future.

As the Governors regularly tell us, they need more, not less, in Federal resources to do the job. Additional Federal commitment will not replace personal responsibility or personal contributions to financing long-term care or to care giving. Those we will all do always. Nor will it bankrupt the Nation. To argue that the Nation cannot afford this commitment confuses affordability with distribution—somebody has to pay—and confuses affordability with policy choice. Choices Congress is currently making, the choice not to tax the baby boom generation, my generation, in the peak of our earning years, and choices to incur enormous debt to finance the Federal Government, these choices are robbing the Nation of our ability, through taxes on a growing, a growing, not a shrinking economy, to serve all our citizens, old and young, fairly and effectively.

We can make better choices, and I hope we will. Thank you.
 [The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PROFESSOR AND DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Chairman Deal, Ranking Member Brown, and members of the Committee, I'm pleased to have the opportunity to testify before you today on long-term care. My testimony will reflect more than twenty-five years of research experience in long-term care, at Georgetown University and, before that, the Urban Institute. Based on that research, my policy conclusions are the following:

- Today, 10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65. Among the roughly 8 million who are at home or in the community, one in five report getting insufficient care, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.
- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance, rather than personal savings. But the nation lacks a policy that assures people of all ages access to quality long-term care when they need it, without risk of impoverishment.
- Private insurance for long-term care is expanding and will play a growing role in long-term care financing. However, even with improved standards and special “partnerships” with Medicaid, it does nothing for those currently in need, is not promoted as a means to serve the under-65 population and, in the future will be affordable and valuable for only a portion of the older population—most likely, the better off.

- Medicaid is the nation's only safety net for those who require extensive long-term care. Rather than serving primarily as a deterrent to the purchase of private insurance, it serves overwhelmingly to assure access to care for those least able to afford that insurance. But its invaluable services become available only when and if people become impoverished; its protections vary substantially across states; and, in most states, it fails to assure access to quality care, especially in people's homes.
- A growing elderly population will mean greater demand on an already significantly stressed Medicaid program, squeezing out states' ability to meet other needs and, at the same time, likely reducing equity and adequacy across states.
- Policy "solutions" that focus only on limiting public obligations for long-term care financing do our nation a disservice. Although individuals and families will always bear significant care-giving and financial responsibility, equitably meeting long-term care needs of people of all ages and incomes—throughout the nation—inevitably requires new federal policy and a significant investment of federal funds.

The following will lay out inadequacies in current long-term care financing; the implications of growth in the elderly population for future inadequacies; and the importance of federal policy to sustain and improve long-term care protection. Unless otherwise noted, I am drawing on research from the Georgetown Long-term Care Financing Project, funded by the Robert Wood Johnson Foundation, and available at our web site: ltc.georgetown.edu. The opinions I present are, of course, only my own.

People who need extensive assistance with basic tasks of living (like bathing, dressing and eating) face the risk of catastrophic costs and inadequate care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people needing long-term, especially younger people, live in the community. Among people not in nursing homes, fully three quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal. Intensive family care-giving comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. Nationally, one in five people with long-term care needs who are not in nursing homes report "unmet" need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded \$50,000 and 4 hours per day of home care over a year were estimated to cost \$26,000. Clearly, the need for extensive paid long-term care constitutes a catastrophic expense.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections of people currently retiring indicate that about 30 percent are likely to die without ever needing long-term care; fewer than 17 percent are likely to need one year of care or less, and about 20 percent are likely to need care for more than five years.

Because long-term care needs are unpredictable and may be financially catastrophic, insurance is the most appropriate financing strategy. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses. However few people have adequate private or public long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Growing numbers of older people, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But private long-term care insurance policies remain a limited means to spread long-term care risk. Private long-term care insurance

- Is not available to people who already have long-term care needs;
- Is not designed to meet the needs of younger people who are also at risk of needing long-term care;
- Is not affordable to the substantial segment of older persons, now and in the future, with low and modest incomes;
- Limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and
- Lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at experience in health insurance to recognize that reliance on the individual market—plagued by risk selection, high marketing costs, benefit ex-

clusions, and other problems—for long-term care will be grossly inadequate to assure adequate protection to most people.

Current public policy also falls far short of assuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required.

It is Medicaid that provides the nation's long-term care safety net. Most nursing home users who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission. But 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted. Because the costs of long-term care are so high relative to most people's income and resources, the opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify—is essential to assure access to care. Some have labeled impoverishment a "fallacy", arguing that the bulk of Medicaid resources go to finance nursing home care for people who could afford to pay for themselves, but who "transfer" their resources in order to qualify for Medicaid benefits. Such exaggeration relies on anecdote, not evidence. Indeed, the evidence shows that few of the elderly have the income or wealth that would warrant such transfer; that people in poor health are more likely to conserve than to exhaust assets; that, for the elderly population as a whole, transfers that occur are typically modest (less than \$2000); and that transfers that are associated with establishing eligibility are not significant contributors to Medicaid costs.

Further, there is little evidence to support the argument that Medicaid's availability is a substantial deterrent to the purchase of long-term care insurance (CBO, "Financing Long-term Care for the Elderly," April 2004). This argument is based far more on theoretical assumptions than on empirical analysis of people's actual behavior. Indeed, analysis of actual purchases of private long-term care insurance found no impact on purchase decisions among older workers and found the slight impact on purchasers over age 70 too small to explain the very low proportion of elderly holding policies (Frank A. Sloan and Edward C. Norton. 1997. "Adverse Selection, Bequests, Crowding Out and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market, *Journal of Risk and Uncertainty* 15, no.3: 201-219).

Despite Medicaid's essential role, however, its protections differ considerably from what we think of as "insurance". Medicaid does not protect people against financial catastrophe; it finances services only after catastrophe strikes. Further, Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14% to 29% of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of eligibility and benefits. A recent Urban Institute analysis emphasized the resulting variation across states in service availability as a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest spending states (New York and Minnesota) were about 4 times greater than in the lowest (Alabama, Mississippi)—a differential even greater than that found for Medicaid's health insurance spending for low income people.

Both our own research and that conducted by the Government Accountability Office tells us that differences in state policies have enormous consequences for people who need long-term care. Studies comparing access for individuals with very similar needs in different communities show that people served in one community get little or no service in another. Georgetown research finds that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And a comparison of use of paid services in 6 states finds almost twice the incidence of unmet need (56%) in the state with the smallest share of people likely to receive paid services as in the state with the largest (31%).

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15% of state spending, with long-

term care responsible for 35% of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low income people needing health insurance, older or disabled people needing long-term care, or both.

In sum, under current policy, neither public nor private insurance protects people against the risk of long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Given inequities and inadequacies in our current approach for long-term care, it is no wonder that we are concerned about the future, when a far larger proportion of the nation's population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of older people will need long-term care in the future than need it today. The population aged 85 and older, who are most likely to have long-term care needs, is likely to double by 2030 and quadruple by 2050.

States will vary in the aging of their populations—with resulting differences in the demand for long-term care and the ability of their working-aged population to support it. To identify future demands on Medicaid, a Georgetown study examined census data on the ratio of elderly people to working-age adults between 2002 and 2025. Nationally, this ratio changes from about one to five (one person over age 65 for every 5.2 people of working age) in 2002 to one to three—an increase of about 66 percent. But the changes differ across states, with some states well below the national average (e.g. California, Connecticut, D.C., Massachusetts) and others, far above. In many states, the ratio increases by more than three quarters and in a few (e.g. Colorado, Utah, and Oregon), it more than doubles. All states will be challenged to meet increased long-term care needs.

States are already struggling with Medicaid's fiscal demands, which challenge their ability to meet equally pressing needs in education and other areas. And state revenue capacity varies considerably. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with above average changes currently spend relatively little per worker on Medicaid long-term care, there is a strong likelihood that in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

What's needed for a different future is public policy action. Developing better policy requires an assessment of options to assure access to affordable quality long-term care and to distribute financing equitably between individuals who need long-term care and their families, on the one hand, and the rest of federal and state taxpayers, on the other. Consideration of federal budgetary implications is an important part of the assessment process. But allowing budgetary constraints to drive that process distorts the nation's policy choices. Last April's CBO report on long-term care financing did precisely that. Explicitly focusing on the achievement of only one policy goal—alleviation of “pressure” on the federal budget—the report treated as legitimate only policy options with the potential to reduce federal spending, without regard to the consequences for people in need.

From this perspective, the report's first set of policy options—cutting back already inadequate Medicaid and Medicare protection—is not surprising. But its implications are nevertheless horrifying. CBO straightforwardly states that such action could reduce the number of people dependent on public programs—a fairly obvious conclusion. But it presents no evidence that people inappropriately rely on Medicaid today; and no evidence that savings or private long-term care insurance would provide adequate protection if Medicaid were made more restrictive for the future. Indeed CBO explicitly recognizes that this approach implies greater burdens on family and friends, greater difficulty in obtaining care, and greater bad debt for long-term care providers. If the policy goal is—as it should be—to improve care and distribute costs equitably, such cutbacks seem unconscionable, not desirable.

The CBO report's second set of options to alleviate fiscal pressure aim to “improve the functioning of the market for private long-term care insurance”—a strategy that is less likely than public cutbacks to reduce access but still unlikely to significantly improve either access or equity. Standardizing long-term care insurance policies might facilitate consumers' ability to make choices in the marketplace and improve the adequacy of private long-term care insurance. But, as CBO notes, standards that improve policies would likely increase insurance premiums. The result might be better protection for those who can afford private insurance—a worthy goal, but

it is highly unlikely to be an increase in the numbers of people willing or able to buy insurance.

CBO's consideration of so-called "partnerships for long-term care"—which would allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved private long-term care insurance policies—also reveals this strategy's limitations. These partnerships have been advocated as a means to save Medicaid money by preventing "spend-down" and asset transfers. The hope is that allowing the purchase of asset protection, along with insurance, will encourage modest income people to purchase private long-term care insurance. Experience with these policies in four states has produced only limited purchases, primarily among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending (Alexis Ahlstrom, Emily Clements, Anne Tumlinson and Jeanne Lambrew, "The Long-Term Care Partnership Program: Issues and Options", Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004). The partnership has contributed to improved standards for long-term care insurance policies and more partnership policies are being sold to more modest income people as the standards that apply to them are also applied to the broader market. However, as CBO notes, if these policies simply substitute for policies individuals would otherwise have purchased or increase the likelihood of using long-term care services, they may eventually increase rather than decrease Medicaid expenditures. From the budgetary perspective, advocacy of reliance on Medicaid to essentially subsidize private long-term care insurance alongside promotion of budget legislation to curtail federal Medicaid contributions seems both disingenuous and risky. Further, from the broader equity perspective, targeting private long-term care insurance to modest income people seems questionable. The purchase of a limited long-term care insurance policy could easily absorb close to 10 percent of median income for a couple aged 60—a substantial expenditure for a cohort acknowledged as woefully unprepared to meet the basic income needs of retirement.

Even more questionable are proposed tax preferences for private long-term care insurance. CBO does not analyze these proposals, perhaps because they would clearly increase rather than decrease public expenditures. Nevertheless, they are consistently on the policy agenda, despite the likelihood that they will be poorly targeted to improve insurance protection. Experience with health insurance tells us that such credits are likely to primarily benefit those who would have purchased long-term care insurance even in the absence of credits—substituting public for private dollars—and, as currently proposed, are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes.

Indeed, the whole focus on reducing public spending and promoting private insurance ignores the public responsibility to address for all Americans what should be our fundamental policy choice: do we want to live in a society in which we assure affordable access to long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own?

There is little question that to address both current and future long-term care needs requires not a decreased but an increased commitment of public resources—and, to be adequate and effective in all states—federal resources. Expanded public financing for long-term care could take a variety of forms and by no means need eliminate private contributions. One option, modeled on Social Security, would be to provide everyone access to a "basic" or "limited" long-term care benefit, supplemented by private insurance purchases for the better-off and enhanced public protection for the low income population. Another option would be establishment of a public "floor" of asset protection—a national program assuring everyone access to affordable quality long-term care—at home as well as in the nursing home—without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. Either public/private combination could not only better protect people in need; it could also provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly requested by calling on the federal government to bear the costs of Medicare/Medicaid "dual eligibles". Because Medicaid serves the neediest population and, in the current budgetary environment is at risk, my highest priority for expenditure of the next federal dollar would be responding to this call (along with supporting more home care and better quality care) with more federal dollars to Medicaid.

Some will undoubtedly characterize proposals like these as "unaffordable", given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices. I would far rather see expenditure of

the next federal dollar devoted to enhanced Medicaid long-term care financing than to tax credits for long-term care or tax cuts in general. Indeed, the estate tax is especially appropriate for long-term care financing: taxing everyone's estate at certain levels, to provide reasonable estate protection for those unlucky enough to need long-term care.

As we look to the future, examination of the choices being made by other nations of the world is instructive. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries (presented at the June 2004 research meeting of AcademyHealth) found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply the absence of private obligations (cost sharing and out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects a "fairer" balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions of elderly than the U.S. does today and therefore can be instructive to us as we adjust to an aging society.

Clearly, we will face choices in that adjustment. If we are to be the caring society I believe we wish ourselves to be, we too will move in the direction of greater risk-sharing and equity by adopting the national policy and committing the federal resources which that will require.

Mr. DEAL. Thank you. Well, I think this panel has truly demonstrated how difficult our task is. You literally are all over the board in terms of perceiving the problem and certainly in terms of suggesting solutions.

Let me start out with just asking a few things, and see if there is any consensus on anything. Okay. First of all, would you all agree that we should attempt to do away with the institutional bias, as Dr. McClellan called it.

I see everybody pretty well—Dr. Feder, you don't agree with that?

Ms. FEDER. I—no, I agree with having a broad array of services available in Medicaid, and I believe that will require the investment of additional resources, and I am absolutely for it.

Mr. DEAL. But you acknowledge the institutional bias is there, and that it does do away with flexibility. All right. Good. Yes. Ms. O'Shaughnessy.

Ms. O'SHAUGHNESSY. Sorry. One thing I would like to point out, and I agree with the supposition about institutional bias. I do want to point out just something from the data, that the acuity level of people in nursing homes has gone up over the past 10 years or so, so people, many people in nursing homes need to be there, but as was suggested, there needs to be a broad array of services as well.

Mr. DEAL. Right. Mr. Moses.

Mr. MOSES. I really think it is critical to understand why we have an institutional bias, and that is because Medicaid came along in 1965, and started paying for nursing homes almost exclusively, which chilled the market for private financing for home and community-based care and insurance to pay for it. So, if we try to retrofit the home and community-based system on what we have before we control the eligibility hemorrhage, we are going to have an enormous problem with that woodwork factor, and with encouraging Medicaid planning and discouraging private insurance.

Mr. DEAL. Okay. Obviously, this is such a difficult issue to get a handle on. We range all the way from are there the rich people in this country who are divesting themselves to become eligible. I certainly agree with Mr. Krooks in this regard. I don't think anybody wants to be a pauper. I do think, as Mr. Moses points out,

that there are transfers being made. It is sort of one of those life cycle things where, you know, you may not have much when you start out. You become a little wealthier as you work, and you accumulate, and you sort of get that attitude like the bumper sticker on the back of the RV going down the road. I am spending my grandchildren's inheritance. And then, you get to the point where you realize that you need institutional care, and it is going to consume everything that you have worked for, and everything that you have saved for, which we, as a people, have encouraged people to do that. We have encouraged them to save. We have encouraged them to buy their homes, and then all of a sudden, all of these are at risk. There is certainly human nature takes over, and to say, I am going to do whatever I can within the law and get an ingenious attorney to figure out what the loopholes of the law are, to preserve that. That is human nature, I think.

So let us back up to another thing, and see if there is any consensus, and I know that Dr. Feder had some reservations about this one, and it is one that Ms. Ignagni, I think you were suggesting in your proposal, and that is, let us incentivize the purchase of long-term care health insurance. Right now, there is not any real incentive, other than the four States in the partnership, if you want to call that an incentive, and we can argue about whether that is an incentive or not. That is, to incentivize the purchase of long-term care health insurance.

Most of us have the attitude that we are not going to need it, you know. And so therefore, if you don't perceive you are going to need anything, why buy it? It is sort of like my mother. I told you about when she lost her leg, and she had to come live with us, and she had to, she called it break up housekeeping, and she was crying 1 day as we were trying to decide where to put this and where to put that, and she says, I just hate to break up housekeeping, and my wife said, well, you know, you knew you were probably going to have to do that at some point, and at 92 years of age, she said but I didn't think I would have to do it this soon.

You know, we are all sort of that attitude. How do we incentivize us to do something for ourselves. You suggested a tax credit. You say it is too expensive. Mr. Krooks.

Mr. KROOKS. Thank you, Mr. Chairman. We support tax incentives which are enacted to encourage consumers to purchase long-term care insurance, incentives that are coupled with caregiver tax credits, because I think, as we have all recognized, the lion's share of care in this country is delivered by informal caregivers, and it is just unfair not to offer a tax credit. People are giving up their jobs, taking time off from work.

Mr. DEAL. Those are the ones I feel sorry for.

Mr. KROOKS. Yeah. The current system is flawed in terms of incentivizing people to purchase long-term care insurance. I am not sure that people do anything because of tax reasons. I don't think the tax tail wags the dog, but certainly, under current law, when your insurance premiums are deductible as a miscellaneous itemized medical expense, which means that they are only deductible to the extent all of your medical expenses exceed 7.5 percent of adjusted gross income, many people don't qualify.

Mr. DEAL. Right.

Mr. KROOKS. What we need to do, and what we have done in other States and in my home State, is offer a dollar for dollar tax credit, so if you buy a long-term care insurance policy, and it is \$2,000, as Mr. Burgess stated, then you get a \$2,000 tax credit. I think that that will go a long way. Although I think we do need to recognize that although we are supportive of long-term care insurance, not everyone is going to qualify. There is a whole generation of people who are 60 plus, 70 plus, who the insurance companies, they don't want them. They want me. The problem is, I have got four kids who I have got to provide college for. I have got 401(k) plan that is half of what it was before the year 2000, and you know, I have got my own issues. So we need to incentivize the insurance companies to insure seniors and people with disabilities, people with MS, because these people are going to have no other choice other than to go on Medicaid.

Mr. DEAL. Let me ask Ms. Ignagni to respond. And I am going to have to cut it off with those responses, and maybe we will get a second round if everybody leaves, and I get back to myself. Yes, ma'am.

Ms. IGNAGNI. Thank you, Mr. Chairman. You made a very important point. A No. 1 issue that we found in our surveys with respect to reluctance to purchase is the denial issue. So we clearly need more education. People are confused about what Medicare covers, in particular. A number of individuals, particularly baby boomers, think that Medicare will cover long-term care. They don't plan ahead. The lack of a tax incentive. We agree with Mr. Krooks. You need an above the line. You also need the caregiver credit, for the reasons that he very aptly articulated. Also, the flexible benefits issue. We know that a number of individuals, in the context of their employee situation, would like to devote pretax dollars to the purchase of long-term care. That is not permissible now. Section 125 accounts, that is not permissible. So, those are very important issues that could be taken to start us moving toward this very productive response and strategy.

Mr. DEAL. If we don't get all the responses right now, we will come back to you, if somebody else doesn't ask a similar question. Mr. Strickland, I will let you next.

Mr. STRICKLAND. Thank you, Mr. Chairman.

And I would like to begin my questioning by yielding some time to Dr. Feder, in case she would like to respond to what you have just said. Dr. Feder?

Ms. FEDER. Thank you, Mr. Strickland.

I just would say that the tax, when you talk about these kinds of tax credits and incentives, unless these tax credits are designed to be deductible, they only go to the higher income segment of society. Several of you members have said they are buying long-term care insurance. That is a fine thing for people to do, but essentially, this whole hearing is about concerns that we—that some think we don't have enough public resources. If that is the case, to invest those resources in the upper end, at the upper end of the income stream seems to me an outrage.

Mr. STRICKLAND. So, Dr. Feder, are you—if I can try to say what you have said, you are saying that these proposed solutions may benefit those who may be the least in need—

Ms. FEDER. Absolutely.

Mr. STRICKLAND. [continuing] and the most able to deal with their long-term care needs without public assistance. So, thank you. Ms. Stucki, I noticed in your testimony that you said there is about \$2 trillion available in home equity from the 20 million, or estimated 20 million elderly households in the Nation. However, I think it would be helpful and useful for us to understand that the portion of that number that would realistically yield Medicaid money for long-term services. For example, Mark Merlis, I understand, at the Georgetown University's Long-Term Care Financing Project, did a study, and he focused on Medicaid or near-Medicaid households who had home equity that would be eligible for a federally backed reverse mortgage. Now, when you narrow in on the target population, Merlis estimated that out of that theoretical \$2 trillion, only about \$4.2 billion would have been available in the year 2000, and the question I have for you is do you agree that this is a reasonable estimate of what Medicaid could actually save?

Ms. STUCKI. Our estimates, if we look at—we are looking into the future, and he looked to the past. But our estimates are in the neighborhood of about \$3 to \$5. If we focus specifically on Medicaid, folks who are imminently likely to use Medicaid. So, I think we are pretty much in the same ballpark.

Mr. STRICKLAND. In the ballpark, of—

Ms. STUCKI. Yeah.

Mr. STRICKLAND. [continuing] somewhere in the range of \$3 to \$5 billion.

Ms. STUCKI. Right. One thing that we have emphasized very much in our report is that we are talking about aging in place, and has been pointed out in other discussions, that is more than just paying for supportive services. It also means paying for appropriate housing, home repairs, transportation, and many other kinds of things that oftentimes are not taken care of under our current system, and when we look at the larger numbers that we have put on the table, what that reflects is the opportunities to help fill the gaps in our current financing. Right now, a person may be able to receive services through various programs to help them with personal care, but nothing to help them fix the roof, and you can't live at home if you don't have that—

Mr. STRICKLAND. [continuing] can't fix the roof.

Ms. STUCKI. Yeah, maybe something as simple as that. So, what a reverse mortgage enables a person to do is manage their assets. It helps fill the gaps in their financing. Even with a long-term care insurance policy, even if they need somebody to help with groceries. An insurance policy doesn't kick in until you are very severely impaired. The equity in your home can help fill that gap and help avoid a cash crunch.

Mr. STRICKLAND. Okay. If I—thank you for your answer, and if I can just follow up with Dr. Feder. Dr. Feder, the thing that is most intriguing to me about all the talk about using reverse mortgages to save Medicaid money is that Medicaid already has the ultimate claim on the home equity of people who receive long-term care. Now, creating incentives, this is related to what we were talking about earlier, incentives for people to use reverse mortgages be-

fore they get on Medicaid just creates a lien on the home by a bank instead of Medicaid, as it is under current law.

So, in the end, is it possible that Medicaid could actually lose money. I would like your response, please.

Ms. FEDER. Short answer is absolutely yes. This is essentially they would be, the dollars would be going to finance these loans, pay interest to banks. And under current law, Medicaid has full access to recover the house.

Mr. STRICKLAND. And so, based on information that has been available to me, it appears that reverse mortgages could perhaps yield something like 60 percent of what Medicaid could eventually receive through estate recovery, so it is defeating what we hope to accomplish, it seems.

Ms. FEDER. I think that is absolutely correct.

Mr. STRICKLAND. Mr. Chairman, my time is up. I yield back.

Mr. DEAL. Mr. Buyer.

Mr. BUYER. Mr. Moses, are you—do you know what the States are doing out there, in regard to going after people's assets, and their homes. Are they being aggressive on recapture?

Mr. MOSES. Well, I have done quite a few studies in individual States over the years. There is a variance between how aggressive they are, in terms of the eligibility constraints on the front end. Just to speak to the issue of estate recoveries, those are not particularly aggressively enforced. It is not—it is kind of a politically sensitive issue. I would just observe that Dr. Stucki said 82 percent of seniors own their homes. Once they are on Medicaid, the best State I have seen is only about 14 percent own their homes, and we have no idea what happened to those assets. So, there is very little to be captured out of the estates, and that is a kind of punitive, after the fact approach that occurs when it is too late for people to do anything. That is why it is so important to convey the message up front that Medicaid is a program for the needy, and that others should take personal responsibility, and either have insurance or tap that equity in the home.

Mr. BUYER. Mr. Moses, Ms. Feder states in her written testimony the suggestion that Medicaid planning is widespread is an "exaggeration," which "relies on anecdote, not evidence." She also states "there is little evidence to support the argument that Medicaid's availability is a substantial deterrent to the purchase of long-term care insurance." What is your opinion with regard to her comments?

Mr. MOSES. Well, as I explained in my formal remarks, there is very little empirical evidence of how widespread this is. But my goodness, all you have to do is open your eyes. Go on the Internet, Google Medicaid planning, and find 1.3 million cases of it. Open the newspaper, and see a program for people on how to shelter and protect their assets. My heavens, I have hundreds and hundreds of quotes and dozens of reports that we have done. I have quotes from eligibility workers, who are extremely frustrated having to act as, in essence, free paralegals to attorneys who are constantly calling, you know, "looking for loopholes." So, there is—where there is smoke, I guess, I am pretty confident there is a good bit of fire here, and if we could just get somebody to do a serious study, look

at a valid random sample of cases, and project that to the Nation, you would have the hard evidence.

Mr. BUYER. Yeah. I—Ms. Feder, I just don't agree with your statement. I practiced law in a little, small town, solo law practice, and I was surprised at the number of the clients, and they are not the wealthy, they have got a small business, or they are trying to shelter their income. They were trying to get some inheritance to their kids, and that is happening out there. So I just want you to know it is a reality that we are trying to face with, and so, you know, do we allow a Medicaid program where individuals are permitted to shelter and transfer their assets so they can pass it on to their children, and then, the ultimate question is, what impact is that going to have on the program, and being able to take limited dollars to real, you know, people who—in need. And that is really what we are struggling with here. I mean, let us just be up-front with everyone. And so, I just want to share that with you, with regard to your statements and how I feel.

I want to turn to the gentleman from Paralyzed Veterans. Your comments, in your statement, you say well, almost all PVA members rely on the Department of Veterans Affairs for healthcare and support services. Potential changes to the VA systems may have ramifications for other Federal programs such as Medicaid. Like what? What potential changes are going to happen in the VA that are going to have ramifications on Federal programs?

Mr. PAGE. Well, if most of our members are spinal cord injured veterans, and PVA, along with the other branches of the Veterans Service Organization recommended the independent budget that we submit to the House Veterans Affairs Committee on healthcare, and from what I understand, the Veterans Affairs Committee has not reported out the budget, that looks like it is going to be a \$2 billion shortage fund—

Mr. BUYER. Sir, wait a second. Time out. Mr. Page, you said that there are potential changes to the VA system are going to have ramifications on Medicaid. I chair this full committee. I know of no, zero, zip, none, changes now or even in the future that may have ramifications—

Mr. PAGE. What—

Mr. BUYER. [continuing] on Medicaid, so please—

Mr. PAGE. What I might mean in that category would be more people that would be eligible for VA would be either turned away from VA, and have to fall back onto other public programs, such as Medicaid or Medicare.

Mr. BUYER. Sir, it was the majority of the Republicans here in Congress that opened up the access that brought many of the special needs veterans into the program, and out of that system. We are placing the priority upon your members, and are taking care of your members. I just want you to know that I am very bothered that you would put a statement in there like this, when in fact, we have made you the priority. So please I want to take that back. I would be more than happy to revisit with you, but I am really bothered that you would put some type of a straw man that you get to knock down before this committee, which in fact is false. So I would be more than happy to work with you. I yield back.

Mr. DEAL. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Well, unfortunately, Mr. Strickland is gone, but he asked the question, I think to you, Dr. Feder, will Medicaid lose dollars through reverse mortgages, and your answer was that is a correct statement.

Ms. FEDER. What he asked was whether, relative to the capacity to get the full value of that—or the full—recover the full expenses by having access to the full value of the house, as under current law, whether—if a reverse annuity mortgage had been in place, then the full value of the house would not be available, and that is what I said could cost Medicaid, could mean there was less to go to Medicaid than is currently available.

Mr. BURGESS. Okay. I like the concept of a reverse mortgage. I don't know if I like it as far as paying for Medicaid, but I do like the concept of aging in place. I think if you age in place, you are likely to die in place, though I don't have any hard data that says that. And I think that is a more economical way to go, no pun intended. But Mr. Moses, you looked particularly pained when Mr. Strickland asked Ms. Feder that question, and it looked like you wanted to respond, so let me give you an opportunity to respond to that.

Mr. MOSES. Well, thank you. I already did, tangentially, but the point is people don't retain their homes long enough for Medicaid to recover them, even if the States were aggressive, and the Federal Government required them to enforce even the Federal laws that are in place. It just doesn't happen, according to the studies that I have done. That is why 82 percent of seniors overall can own their homes, but by the time they are on Medicaid, most of that home equity is gone. I did a study in Nebraska a couple of years ago, and what we found is while there was very little evidence of egregious Medicaid planning, like what we have talked about today, people routinely, in the course of estate planning, transfer their assets, ownership of the farm or the small business, to the next generation, around their late 60's, early 70's, never intending to qualify for Medicaid for their long-term care. But a decade goes by, all of a sudden, mom needs nursing home care. The family can't handle it, because everybody is working now, and voila, eligible for Medicaid, and nothing to recover out of the estate.

Mr. BURGESS. Thank you. I think that is worth repeating. Ms. Ignagni, the question comes up, and I think you addressed it in some regard, about why more people aren't purchasing long-term care insurance. I said for the record that I had. I didn't do that because of legislation. I didn't do that because of a tax break. Again, I did that because my mother told me to do it, and it was good advice 5 years ago, and I think it would be good advice today. But why aren't more people buying long-term care insurance?

Ms. IGNAGNI. I think, Dr. Burgess, there are several reasons. One is that people are generally not thinking ahead. They are in denial, particularly about care that—conditions that might incapacitate them. So that is No. 1. No. 2, I think that there is very little information broadly about whether or not the Medicare program covers long-term care. We find that repeatedly in our studies. Third, you want to encourage the purchase at a time when it is most affordable, so the employer vantage point is particularly productive in that regard. And we are seeing that by far, employees would like

to purchase, but the barrier of not having tax subsidies for flexible benefit purchase, 125 purchases, and through the kinds of accounts that people routinely decide how they want to dedicate their assets, that really holds back the middle class. It doesn't restrain or constrain folks who have a great deal of income on the high end, but we are really constraining the middle class from thinking ahead.

A final point on your question to Dr. Feder and Mr. Moses, with respect to reverse mortgages. One thing that hasn't been said all day, or observed, as individuals are, appropriately, we think, excited about the potential to put new assets on the table, is that how far will those assets go if you don't try to purchase long-term care insurance with those assets. If the average cost of a nursing home stay is \$70,000, and if Mr. Krooks' example is any suggestion of the modal value of a home today, then 2 years in a nursing home would cost \$140,000. So even when we talk about an individual purchasing at arguably the most expensive time, or purchasing long-term care, it is prudent to begin to think about, also, that concept, with the idea of stretching the resources to make them go farther. And we would like to very much in—be involved in those discussions with the committee.

And that applies to the partnership concepts, in terms of what we can learn from what is out there in the market, and how we can extend those to a 50 State partnership program.

Mr. BURGESS. Right. And I may have been out of the room when he talked about partnerships, but that seems to me, greater than tax credits, that seems to me to be a vehicle to get people to think about long-term care insurance. Here is a way to—a legitimate way to shelter your assets. Buy the insurance policy up front, those assets are protected up to the extent of your long-term care policy.

Ms. IGNAGNI. That is right. There are 180,000 people who have purchased insurance under the partnership programs. Only 89 of them have spent down to the Medicaid levels. And so that is important data, not to be dispositive, but to give us a suggestion on a range of strategies that might work together. And the final thing that we haven't mentioned in the last few minutes is what can be done, Governors working to stretch their resources in the context of the Medicaid program, we think we can offer strategies there to—for the folks who are at the bottom of the economic distribution, who are depending on Medicaid for a safety net. We think that there can be more done in the area of bringing private tools to the SSI population, et cetera, and we are very much involved in those discussions at the state level.

Mr. BURGESS. I want to thank everyone. I know we may have another round of questions. I may not be able to stay. You see why Congressional representatives can't think in paragraphs.

Mr. DEAL. I thank the gentleman. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman, and I want to thank the panel for being patient, and as I said to the other panel, we have some great challenges to tackle, and we ought to be—we shouldn't be fighting and bickering. We ought to be trying to find a solution, because as in the first panel, the demographics, they speak loudly. And we are talking about mandatory spending, spending that is—we have no control over, because of the policies that we have put in place. We have to spend these dollars, unless

we reform it. So I think the chairman, who I have great respect, and I hope he appreciates—I loved his questions trying to—well, what do we agree upon. Because we have to first get there before we can address—and we are trying to do that with the Governors. We have a short-term problem, and we have a long-term problem, and we ought to look at—in both of those arenas, to address this. And that is why we have this—a lot of these different issues on the table. As you know, short-term, we might look at drug prices, average wholesale price versus average sale price. We look at the asset protection issue, and it is, I think, a credible issue. You follow the money or you follow the advertisements.

I have a medical liability crisis in my State. And everybody says the insurance companies are making money hand over fist. Well, guess what, there is only one insurance company down in southern Illinois, and it is a co-op. It is a not for profit entity funded by docs so that they can stay in southern Illinois. If they were making gazillions of dollars in medical liability insurance, you would have people all over the place. So why, when you Google asset protection, Medicaid, why do you have thousands of ads, and we have them all here, all these comments about you know, how do you protect yourself, and how do you then protect your assets so that the government pays for your Medicaid care. Because they are making money on it. There is a demand for it, otherwise these guys would find another line of work. So, I find—I really get troubled by us not just looking at facts openly.

Let me ask a question—I want to get one to Ms. Ignagni on the long-term care insurance, and anybody else can jump in, many of you were here for the other panel, and know that I am involved in the disability community. How do individuals access that if they are already disabled? Is there—I mean, are they means—not means tested, but what—I don't even know the terminology, but are they preexisting conditions and are—they have trouble accessing this, in this environment now? And then, if you can do quickly, then I want to talk about long-term and throw something out on the table that should get everybody's attention.

Ms. IGNAGNI. Yes, sir. Thank you for the question. There are two ways to access right now. One is through, as an individual, going to a broker, the way you would go for auto insurance, car insurance. And your age is looked at, your medical condition, and the pricing is determined. Eight insurers represent 80 percent of the industry, and they haven't had price increases, so there is a great deal of stability in the market, and we would be delighted to provide data.

No. 2, there is another way to access, and this, we would like to see, and we have recommended strategies to encourage in the context of the employer group, where there is broad pooling, the opportunity to encourage individuals to think ahead and purchase, we think this would go a long way for working families to help supplement their savings to think ahead for long-term care.

Mr. SHIMKUS. Illinois is a pretty successful insurance State. One of the reasons why is it doesn't regulate the price. It does regulate, it does have a State insurance commissioner. It does intervene, but they allow the competitive marketplace to be involved in setting the prices. A lot of States don't have that program and process.

When you drive a car in the State of Illinois, you are mandated by law to have health insurance. Why not for catastrophic health—I mean automobile insurance, and why not for catastrophic health insurance coverage, or long-term care, out of the box, long-term, why don't we mandate everybody to have a policy? You pay it yourself, the business helps subsidize it, or if you are—can't afford it, then the government intervenes, and we use the taxpayer's dollars to move from a centralized market economy on healthcare to a competitive marketplace, which may put emphasis on preventative care, and options from institutional care to home care.

Ms. IGNAGNI. Is that to me, sir?

Mr. SHIMKUS. You can.

Ms. IGNAGNI. Thank you.

Mr. SHIMKUS. And maybe someone else may want to jump in, but—

Ms. IGNAGNI. The issue of how we expand access, both for acute care services, access to services, and coverage, as well as long-term care, is a very large question. I am not going to duck it, though. I think that one of the things that we have tried to recommend here, recognizing that people have a variety of opinions about that issue. Should we mandate, shouldn't we, et cetera. Is the idea of putting down on the table strong incentives to grow the market, to expand the pool, as a first step. To look at the successfulness of that, to be able to think of Medicaid as a safety net for individuals who have low income, to encourage the middle class. Folks who have significant resources will always prepare for themselves, and we don't need to worry as much about them. But it is the middle class. So, we think that that would be an operative and effective first round strategy, because we think that there is a great deal of support, recognizing the bipartisan nature of support for the legislative proposals. It could move forward. It could be a very significant, productive thing.

Mr. SHIMKUS. And Mr. Chairman, I kind of threw that out there. My time is out. However you want to manage this. I will leave it to your call. Thank you, Mr. Chairman.

Mr. DEAL. We probably are going to be up against another vote here in a minute. Let me go to Mr. Rogers, and get his questions. If we have time, we will come back.

Mr. ROGERS. Thank you, Mr. Chairman. Mr. Krooks, I just—according to two elder law attorneys in Seattle, their average Medicaid planning client owns a home free and clear worth between \$250,000 and \$400,000, has another \$150,000 to \$200,000 in liquid assets, and an income of around \$20,000 to \$25,000 a year. Is that about right from your experience, or would you put that high or low, or average?

Mr. KROOKS. It is probably slightly on the high side nationwide. I mean, it is geographical. In New York, the homes are probably more, or California. But I would say nationwide, it is probably slightly on the high side.

Mr. ROGERS. And I just want another quote, if I can. So if there are any—if there is—so is there, excuse me, any practical way to juggle assets to qualify for Medicaid before losing everything? The answer is yes. By following these tips on these pages, an older person or couple can save most or all of their savings, despite our law-

makers' best efforts. Doesn't seem like an honorable business to me to circumvent the system designed to take care of those who are most in need. I mean, is this a problem nationwide?

Mr. KROOKS. No. I think, you know, in the legal business, the Supreme Court has ruled that lawyers are allowed to advertise. And I think what you are seeing is the price that society pays when a few bad apples spoil the bunch. I can tell you that the approach that our firm and that the majority of elder law attorneys take is vastly different from the attorney whose quote you just read. We help clients deal with legal issues of aging. The Terri Schiavo case, I can't tell you how many cases we get involved in where we are helping clients work through end of life issues, advance directives.

Mr. ROGERS. But you also do Medicaid planning.

Mr. KROOKS. Yes, we do. Yes, we do, and our average Medicaid client is on a fixed income, is living off Social Security and pension. People with money don't want to give it away. Seniors are—want to control their own destiny. They are not about to give away money. It is just not reality, and I think the reason why we don't have any data on it is because, frankly, it just doesn't exist.

Mr. ROGERS. So the laws are complicated enough to allow lawyers to quite frankly earn a living helping people navigate through Medicaid. Is that correct?

Mr. KROOKS. Not dissimilar from estate planning or tax law. That is correct.

Mr. ROGERS. Well, that at least tells us where we have to go, I think. Ms. Hansen, I just—a quick one. I was kind of struck by something in your written testimony. You offer long-term care insurance through AARP? In your testimony, it said, and I quote "Long-term care insurance is limited and generally expensive." Are you promoting your long-term insurance by telling your customers it is limited and too expensive?

Ms. HANSEN. Well, I think our point is our subsidiary does offer, through a contract, a long-term care insurance. I think our point is that only about 20 percent of seniors, or people over 65, often-times have the disposable income to purchase long-term care insurance, so I think we are stating just a fact that many people are not in a financial position to purchase it, and so—

Mr. ROGERS. I am sorry. What was that percentage again that you said was eligible? I just—

Ms. HANSEN. About 20 percent of the people who are 65 and older, because you have to have enough discretionary income to pay for that kind of premium.

Mr. ROGERS. And what is your target group for getting people into your insurance premiums, your insurance package on long-term care?

Ms. HANSEN. I think the general target group would be similar to any of the eight major groups that are selling long-term care insurance, and these people probably would normally have at least a \$35,000 income level in order to have some discretionary income to do that.

Mr. ROGERS. So do you think tax incentives would help that particular group, in fact, encourage them to buy insurance?

Ms. HANSEN. I think it is one of the options to take a look at at this point. I think one of the things that we are saying is that, in the spirit of looking at this broadly, there is not one single solution or one factor alone, and so, if these are brought up as topics of possible consideration, we would just like to have that conversation with you.

Mr. ROGERS. And Dr. Feder, you said something that struck me as well, is that—in your mind, that these tax incentives incentivize the wrong group of people to buy insurance. Is \$35,000 a lot of money?

Ms. FEDER. What I am concerned about is that the people—for people, \$35,000, it is still, if you talk about a premium, say \$3,000 a year, you are talking about 10 percent of their income. If you lower that a little bit, it is still a lot of money for those folks. I suspect that the people who are most likely to take advantage of a tax credit are going to be those who were likely to buy anyway. We know that. That is true of tax credits in other areas. It simply substitutes this new public expenditure for private expenditures that would have been made anyway, which is exactly the opposite of what you are trying to do.

Mr. ROGERS. Thank you. Do you agree with that, Ms. Ignagni? I—

Ms. IGNAGNI. I think the market is being held back, because middle class people don't have the existence of subsidies. If you think about a \$40,000 per year individual, they would have to spend \$3,000 before they could deduct anything from there. And if you look at the tables that we have supplied, in terms of the cost of insurance, you can see that that goes, the expenditures for even someone at the 65 year level could be under that. So, I think that they wouldn't get any credit for that purchase, and I think psychologically, that is a very significant barrier. We agree with Dr. Feder that the Medicaid system itself should be at a strong safety net for individuals at the lowest part of the economic distribution. But we definitely think that the lack of tax support is a significant barrier for the middle class. And we see this in the surveys repeatedly, particularly with respect to people who have the opportunity to use flexible benefit dollars, would like to have the opportunity and cannot, and that is a very good place to shine a spotlight on what the behavior is likely to be.

Mr. ROGERS. Sure one thing I can tell you, Mr. Chairman. I think I can see the problem. You have the hardest job up here, I think, trying to sell insurance when there are whole groups and institutions out there saying don't buy insurance, we are going to promote the government to do it, and if you can't do that, go see a lawyer, he will get you around the rules anyway. It has got to be a tough—I can see where we need to come together on some consensus here, so that we are all promoting—I happen to be a free market guy, that promotes the purchase of that insurance, versus this kind of really dysfunctional family in the long-term care, of which we are equal members of that, by the way. I thank you all for what you do, and thanks for all, for being here. Thank you, Mr. Chairman. I yield back.

Mr. DEAL. The gentleman's time has expired. Welcome, Mr. Engel. These folks have been here since 10 waiting for your questions if you have any.

Mr. ENGEL. Well, Mr. Chairman, was it 10 last night, or 10 this morning?

Mr. DEAL. Well, I can assure you that those of us who have been here can tell you it was 10 this morning.

Mr. ENGEL. Okay. Well, I just have a couple of questions, and I am just—I will try not to keep them much longer, but I understand there has been some discussion about people who are supposedly divesting their assets to qualify for Medicaid, and I would like to ask Ms. Allen, that the GAO has done some past work in this area. I would like you to please tell me what you found. Some estate planners are saying that the wealthy are divesting themselves in order to qualify, and I wonder what GAO has found.

Ms. ALLEN. Yes, sir. The last time we looked at this was in 1997. We had a very short timeframe, so we scurried to gather together the most available information at the time. What we were asked to do was to look at the prevalence of asset transfers with intent to qualify for Medicaid. We found just a few limited scope studies, but what we did find was that in a couple of States, we found case studies where approximately 13 to 22 percent of individuals who applied for nursing homes had transferred some assets, but many times, it wasn't enough to even cover 1 month of care, and in most cases, was insufficient to cover 1 year of care. A little earlier than that, in 1993, we did some empirical work ourselves. We went to one State, drew a random sample of about 400 cases of persons who had entered into nursing homes. We found of those approximately 400 cases, about half had transferred some assets, but the amounts were relatively small, and even half of those who had transferred assets, this particular State denied them Medicaid eligibility, because what they had done was not consistent with State and Federal law and regulation.

At the current time, we have work in process on this issue. Some members of this committee have asked us to undertake work to look at the prevalence of asset transfers to qualify for Medicaid, and we are hoping to have some information available in the next few months.

Mr. ENGEL. Dr. Feder, I am wondering if you could comment on the same thing. Have you seen any evidence?

Ms. FEDER. That is—I am delighted that you asked about the GAO study, because I was going to cite it as well. I think that there is very little analysis that zeroes in, actually, on the asset transfers, and I think that Ms. Allen has articulated well that the evidence that exists shows that it is very rare and very modest. The broader research on this field looks at the resources that people have available, and the way in which they are using those resources. And the bulk of that literature indicates that people are actually saving more money than you would expect them to as they approach long-term care needs. They are not spending down at the rates expected. They are doing less. And that they are not transferring substantial assets. Although everybody is concerned about this advertising, when you actually look at behavior, we find that it is modest indeed.

Mr. ENGEL. Well, thank you, Mr. Chairman. I ask unanimous consent to include in the record this GAO study, where GAO notes that in their study of one State, the average amount of assets converted was \$5,618. In almost all cases, for burial expenses only.

Mr. Krooks, would you like to add anything?

Mr. KROOKS. Sure. I think we are losing sight of two very important points here. I think we all agree that insurance needs to play a larger role in the overall solution. However, I have not heard one credible idea about how are we going to take care of the people who are uninsurable. I have heard an idea about well, we need to define a line based on how much income you make as to whether or not you can afford insurance. But what about the people who are not insurable? I also think that this myth about people transferring these assets, we need to either prove that or move on off of it. Because middle class America does not wake up each morning and say, you know something, I am going to go to my local elder law attorney today and I am going to figure out how to qualify for Medicaid. Even clients with \$150,000, those are married people, so would this Congress have the community spouse, the wife, spend all of their money taking care of her husband in the nursing home, who is going to stay there for an average of two and a half years, spend the \$150,000, and then, she becomes a public charge on welfare. I am not sure that that is the type of social policy we want to endorse.

Mr. ENGEL. Thank you. Mr. Chairman, I have one question I would like to see if I can get in. I would like to go back to Dr. Feder, and I am wondering if you can talk to us about your concerns with long-term insurance. I recently had someone come to sell me and my wife long-term insurance. I understand Ms. Ignagni has testified to the benefits of long-term care insurance. We weren't sure it was really appropriate for us. I am wondering if you could help us with what population do you feel it is really appropriate for, and what kind of consumer protections are necessary, if someone is serious about buying the policy?

Ms. FEDER. I think that it is appropriate for, with appropriate consumer protections, for people who are able to pay well, long into the future, the premiums that it will require, and I think that is a substantially upscale population, higher income population. Because one of the things that happens to people is that even if they start out buying those policies, they buy—and they are encouraged to buy them years in advance. If they buy a policy, say, a median income couple, this is whom I think it is not appropriate for, a couple at age 60, it is going to take 10 percent of their income. That is too much. So, say, a 50 year old couple can buy, can—wants to make that investment. They are likely to be paying premiums for the next 20, 30 years before they need long-term care insurance. They also, at the same time, have to save for retirement. We know that that age cohort has put away much too little for retirement, for basic income needs of retirement. So, it is quite possible somewhere in that period, they would find themselves needing their resources to live on, rather than to pay their insurance premiums. Without protections on non-forfeiture, inflation protection, a whole array of consumer protections, they would find that they had paid

years of premiums, and when the need came along, they would get nothing.

We can do a lot with consumer education, so that only people with substantial resources, less risk of falling into that trap, are likely to buy these policies. Even they may find they get less out of them than they had hoped, but affluent people, and I would include myself, we can prepare to take those risks. Modest and lower income people are not the appropriate target population for this benefit. And I would again repeat that when we are talking about using what is continually described as limited tax dollars, this is not the first order of business. The first order of business is to sustain and improve the Medicaid safety net, which is—useful and important as it is, is grossly inadequate today for the population who needs long-term care, and only becoming more so. That is where our attention needs to go.

Thank you.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Ms. DEAL. The gentleman's time has expired. We are going to take a real quick second go around here. I don't want to detain you all too much longer. But I had a couple of questions, and I know Mr. Shimkus, I think, maybe had a followup as well. You know, we can have differences of opinion about a lot of things, as we have here today, but my staff has just provided me with this little tidbit of information. If we want to know whether or not asset transfers and planning to become Medicaid eligible is happening out there, some would deny it. I am told that on Google, there are 2,140,000 websites, that on Yahoo, there is 1,780,000 websites dealing with that issue. Now, I would suggest that if you want to follow the money, and find out where the issue is, you find out where people are advertising and what they are doing it for. They are not doing it just for their own enjoyment or their own health. There is transfer going on. We can debate that all day long. But let me ask you something, back to my concept of what can we agree on?

I think one thing we probably can all agree on is that the current system of reducing you to absolute poverty, assuming you have taken advantage of the transfers or whatever to get there, that that is demeaning. Would everybody pretty much agree with that? If you do, then, and if we are dealing with this home, for example, that can be of unlimited value, and is excluded from the picture, furnishings, including expensive paintings we have all heard about, that are excluded from the calculations of your eligibility, what would we come to, in terms of establishing a reasonable level of assets that you could retain, and I think retain your dignity in the process, and still become eligible? Would it be a number that is equivalent of, say, the average cost of a home in this country? And if we choose that, should we then say that homes that are valued in excess of that amount would not be excludable, or furnishings of a certain level, that are valued above a certain amount, would not be excludable? What about those things? Can we agree on things like that?

Mr. KROOKS. No, Mr. Chairman. That is—with all due respect, not a good idea.

Mr. DEAL. Why?

Mr. KROOKS. The home is sacrosanct. We are encouraging people, through the use of—

Mr. DEAL. Yeah, but you are willing to take their home away from them after they have passed on, you are willing for the government to come seize it.

Mr. KROOKS. The government.

Mr. DEAL. Everybody over here voted for that in 1992, with President Clinton's first budget. Asset recovery.

Mr. KROOKS. That is correct.

Mr. DEAL. Okay.

Mr. KROOKS. But to force a sale of a home, I believe there is a distinct difference between forcing a sale of a home while somebody is alive, and then, having a State recovery action after they pass away. We can't have policy in this country encouraging people to buy homes, and then say well, if you happen to have the wrong disease, then we are going to make you sell it. I also want to just take a chance, this opportunity, to respond to the Internet issue. I think that if your staff takes a closer look, and I am not sure what term they put in Medicaid planning, or elder law planning, whatever, many of those hits are actually long-term care insurance sales brokers, so—

Mr. DEAL. I thought nobody was interested in that.

Mr. KROOKS. No question about it. So—but I don't—I got the sense here that we were coming to the conclusion of—

Mr. DEAL. Okay. So you don't agree on setting any limit for a residence.

Mr. KROOKS. Not on the home, no. Not on the home.

Mr. DEAL. The multimillion dollar mansion ought to still be able to sit there, and not be touched, and a little old lady who has got two children and she is a single mom paying her taxes ought to pay for the multimillionaire's house sitting out there.

Mr. KROOKS. But it is not a multimillionaire's house. It is a house they bought for \$20,000 or \$50,000—

Mr. DEAL. No, he could pay a million dollars for it and still be excludable.

Ms. FEDER. Mr. Deal, the—what I think you are—what you spoke about a minute ago, in terms of estate recovery, what you get, you can get this money after the fact. It is there, so you can—if you are serious about that—

Mr. DEAL. Nobody is serious about that. My State just finally got around to it this year of passing something to implement the 1992 statute.

Ms. FEDER. Well, you know, I think that is really interesting. If the State is not interested in it, because it is because the people in your State don't want you to do it, in which case—

Mr. DEAL. I agree with that.

Ms. FEDER. Well, then, if that is the case, what we really ought to be doing is saying to people in your State and in all States, if you want to rely on this program, rely on a public program, then we need to all contribute from all our resources, all our estates, to pay for that.

Mr. DEAL. Okay.

Ms. FEDER. Maybe that is what people are telling you.

Mr. DEAL. Let me take you to task with your analogy about that you don't agree that we ought to spend any tax incentives to incentivize purchase of long-range—long-term health care insurance, that you are better off spending that money that we realize by those tax dollars, by putting money into the current system. If you use that analogy, then you would do away with the deductibility of the home mortgage, and you would say we shouldn't be giving taxpayers a break on home mortgages. We should use that tax money to put more people into public housing, and spend the money there. We shouldn't allow them to have charitable deductions. We are losing tax dollars by recognizing a charitable deduction, and we ought to just let the government take care of them, instead of what the charities are doing.

Ms. FEDER. Well, actually, Mr. Deal, no, I think there is both legitimacy and questions about the point you make. The—in terms of the discussion here today, we are talking about, I have heard several people talk about having difficulty sustaining the Medicaid program that we now have. And what I am objecting to in regard to using tax dollars that are likely to go to higher income people is that if we don't have money, enough resources, if you think we don't have the tax dollars to support the population in greatest need, then I do not see how you can invest more money in, invest the next dollar in higher income people instead of the population in greatest need who are now being cutoff Medicaid. That is the first thing.

Mr. DEAL. Okay.

Ms. FEDER. The second thing is, I think you are—I think there are, in looking at the comparison to mortgage deductions, pension deductions, health insurance deductions, those—all of those deductions are absolutely entitlements that are now in law, that go disproportionately to the better off members of our society.

Mr. DEAL. So, you would repeal those, then.

Ms. FEDER. I would not repeal them. I would recognize—

Mr. DEAL. We are going to have a whole lot of middle income folks upset with that answer.

Ms. FEDER. I would—I know that. I would recognize that they exist, and that we are devoting resources there, and at the same time, we ought to be willing to take advantage of those who are less fortunate and not able to take advantage—

Mr. DEAL. Doctor, with that, I am going to close with this, and challenge you. All I have heard you do is criticize other people's suggestions about what to do. Would you submit something in writing to us as to the kind of things, other than just putting more money into a system that almost every Governor says is failing, and is leading to their bankruptcy? Would you give us something in writing, positive things you think we can do?

Ms. FEDER. I would be delighted, but if you constrain me to not use more resources, I cannot do my job.

Mr. DEAL. Use your imagination. Mr. Shimkus.

Mr. SHIMKUS. Mr. Chairman, Mr. Strickland came back. And—

Mr. DEAL. Oh, I am sorry. Excuse me, overlooked you. We have been talking about you while you were gone. I recognize you, we are going to go around one more time.

Mr. STRICKLAND. Well, I can always trust Mr. Shimkus to look out for my wellbeing. Thank you. Thank you, John. Ms. Hansen, a question directed toward you. Some of us have suggested that requiring individuals to tap into their home equity before they can access Medicaid coverage for long-term care, some have suggested that that be done. I understand that AARP does not support that idea, and could you please describe some of the potential dangers of doing that? For example, isn't it possible that requiring a reverse mortgage could mean that Medicaid would actually wind up spending more on care for some individuals, because the bank, not the State, would be the one to recover against the home, and thus, the State would not be able to recover the costs it spent on care, or another concern I have is that much of the home equity goes to pay lender's fees and interest, and other associated mortgage costs, rather than to pay for the actual care of the patient. Would you just comment on that, please?

Ms. HANSEN. Well, Mr. Strickland—

Mr. STRICKLAND. And then, I would like for Dr. Feder to also comment.

Ms. HANSEN. Yeah. I think, actually, the answer I would have given is the comment you have made. In other words, the first money is already taken away by the fees, the upfront fees, in order to pay for the home equity mortgage, or reverse mortgage, that that is the first fee that goes. And when that is gone, and they—what happens is Medicaid does not even have that in order to recover. So, I think that the ability to make sure that there are the funds there for the person to use, and I think the suggestion was if it is to be used, we just still would like to make sure that the choice for services and all versus long-term care insurance, but we are concerned about the upfront costs, which is why we would suggest, in order to encourage this, or see that this is a viable option, is to really take a look at some pilots on the process.

Mr. STRICKLAND. Okay. Dr. Feder.

Ms. FEDER. I would only reinforce what Ms. Hansen has said, and take it just the point further, which is that people, in looking for ways to find some kind of money some place else, or ignoring what really is the reality, which is that we need support for the public system that we have got.

Mr. STRICKLAND. Thank you, and my second question. Dr. Feder, I have a document from the National Association of Health Underwriters that includes some interesting information and statistics on the long-term care partnership program as of October 2003. For example, in California, there were 67,500 applications for partnership policies. However, 11,897 were denied. In New York, 65,987 applications were received, and 10,595 were denied. Approximately one out of every six applicants were denied. Now, a number of witnesses today have said that we should do more to force people to purchase long-term care insurance. However, given the statistics that I have shared with you, isn't it true that there are a whole range of individuals who can't even get such coverage if they tried?

Would you please comment on these statistics and this problem?

Ms. FEDER. Well, I think—I can't speak to the specific statistics about the partnership, but the broader question you raise, about people being unable to get coverage, I actually thought that was

what Mr. Shimkus was asking earlier, when he spoke to Ms. Ignagni about people who have long-term care needs and disabilities, whether indeed they have access to long-term care insurance. They don't. That is because there is always a concern among private insurers, understandable, that if people who need the services are the ones who buy it, it means they have got to have more money to support those claims. That hikes the premiums. It means fewer healthy people buy. Insurance can't work that way. So it is understandable that people are kept out of that private insurance market. But what it means is that people who now need long-term care, old or young, cannot buy this coverage, and that is as true of the Federal employees long-term care benefit as it is of the rest of the industry. So, given that the—our long-term care protection is inadequate now, for younger and older Americans, to wait decades for a solution that will only do a partial job seems to me a highly questionable way to approach this problem.

Thank you.

Mr. STRICKLAND. I thank you both for your answers, and Mr. Chairman, I yield back my 35 seconds.

Mr. DEAL. You are generous. I thank the gentleman. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. Again, I am very pleased with this hearing, and I appreciate your patience. This is, as you can see, it is a tough issue, and we are grappling with it, and trying to wrestle with these concerns. . And we all have real life stories, as people said before. My grandmother suffered dementia. We actually sold her house to pay for 3 years of long-term care, and then Medicaid picked up the final seven. I think—and it was good. It was good that we paid for—or 3 years was paid for, and it was good that Medicaid was there to cover her.

My parents live in the home that my grandfather built. But that is not the story for all seniors. A couple issues in this debate, is I don't know how to define wealth in America any more. What is affluent, what is modest, and what is low? In low, we use the poverty level, or 125 percent of poverty, 150 percent of poverty. But what is modest? And that was the question about \$35,000 a year. In parts of my district, that is above the average income of my Congressional district. So that would be considered well off, middle class, upper middle class. So I think when we start to talking about incomes, we ought to start putting real dollars down, and I think that would help us all.

Mr. Krooks, in your line of work, do you—there is an issue about the—in fact, I don't know if it has been quoted today, the editorial in the Wall Street Journal. Two clients, or people that you deal with, are you involved in this stuff called asset shifting or buying up?

Mr. KROOKS. I am aware of the Wall Street Journal editorial, Congressman. The asset shifting or buying up, I don't know what that means.

Mr. SHIMKUS. Well, I will tell you what it means. It would mean that my parents, instead of living in a home that my grandfather built, upon getting a certain age, they end up buying a \$250,000 home. In this, you know, what I am trying to do is address this debate of this—how sacred a home is.

Mr. KROOKS. Okay.

Mr. SHIMKUS. Now, I will tell you that my—the home that they live in has no garage. It is a very sacred home for them. My mother has said she will be carried out of it. And so I appreciate the comments of how sacred that home is. However, if my folks were getting good legal counsel from the National Association of, what are these NAEA guys? National Association of Elder Legal Attorneys, and they said get a two car garage. Buy one that is \$250,000, the terminology is buy up, the house is sacred. We are not going to go after that, and you hide your assets, because now, you are paying, you have a mortgage, or it is no longer a full asset of your own.

Mr. KROOKS. Okay. May I respond?

Mr. SHIMKUS. Please.

Mr. KROOKS. Okay. First of all, Medicaid is like the drive through. Either you pay on the way in, or you pay on the way out. So—

Mr. SHIMKUS. But we—I think—in the—but we have come to the conclusion that if 82 percent of seniors own homes, and then, when they qualify for Medicare, 14 percent actually identify a home as an asset, where is the other 60 percent going? So I think part of this hearing has accepted the premise that no, it is not, because States aren't collecting at the end.

Mr. KROOKS. Okay. In my experience, I have never had a client buy up. What I have had is clients who will spend money on their homes to make them handicap accessible, to put in an elevator, or handicap ramp, or handicap bathroom. I have had clients do that. I have been practicing law for 20 years, and I am, frankly, I am not aware of any of my colleagues, I am not saying that nobody does it, I just don't know of anyone who engages in that type of advice. In terms of the estate recovery, I think that I would disagree that people are transferring their homes.

Seniors want to die in their homes. I think we have common ground that. To give away the house, and then run the risk that the children are going to kick you out 1 day, or that you are going to subject your estate to gift or capital gains taxes just doesn't make sense. So, I don't know why the States aren't recovering, and I don't know what is happening to the homes, but our clients are not giving away their houses. Where are they going to live?

Mr. SHIMKUS. Are you providing, and I don't want to give you any, I mean, private consultations or stuff, but do you in the practice, and I think most people understand, making sure the spouse is able to keep the home, but what about heirs, children?

Mr. KROOKS. Well, there are certain protections in the law. Let us say you have a child who has lived at home, taken care of the parent, provided care to that parent, that kept the parent out of a nursing home, to save the Federal Government and the State's money, then there is a protection in the law that allows the parent to pass on that asset or that house to the child. It is called the caretaker child. I think again, that is good policy. We want children to take care of their parents. Other than that, if a parent transfers a house to a child, they are not going to be eligible to receive Medicaid in a nursing home for 3 years. So either they are going to pay for those 3 years out of pocket, or they are not going to get care. There is no other way around it.

Mr. SHIMKUS. Thank you, Mr. Chairman. I—even though there are some contentious periods, this is a very important debate, and I think—everyone ought to be encouraged to keep coming back to committee members, talking through this, and hopefully, trying to find some common ground. I would encourage that.

Thank you, Mr. Chairman.

Mr. DEAL. Thank you. Ms. Myrick.

Ms. MYRICK. No, I am sorry. I had to be gone. So I did not hear your testimony per se. I do want to thank you for what you have done by coming here, and I will get copies of what you said, so I can find out.

Mr. DEAL. I thank the gentlelady.

Well, you thought you were just going to come testify. This is an endurance contest up here, as you found out. You have all been great. I know that there were things that you would have liked to have said that you didn't get a chance to say. We would be glad for you to contact us and provide us with whatever else you would like to say.

It is a difficult subject, one that I appreciate the fact that all of you have weighed in on and taken the time to do it. And this committee especially appreciates your presence here today.

Thank you. The committee is adjourned.

[Whereupon, at 5:20 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]



Memorandum

September 2, 2005

TO: Honorable John D. Dingell
Attention: Amy Hall

FROM: Carol O'Shaughnessy
Specialist in Social Legislation
Domestic Social Policy Division

SUBJECT: Hearing Questions on Bias Toward Institutional Care in Medicaid's Long-Term Care Services

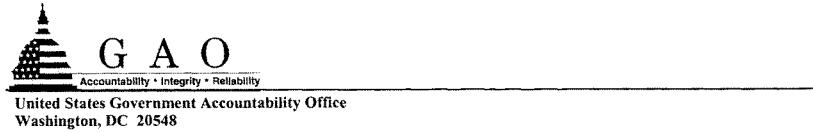
This is in response to your request for comments on ways to eliminate the bias in Medicaid's long-term care services toward institutional care, in follow-up to the hearing entitled, *Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform*, held on April 27, 2005. The following presents background on Medicaid's institutional bias and various options that may be considered to eliminate or reduce such bias.

Background

Over the years, significant federal research and demonstration initiatives have been focused on ways to improve home and community-based care and to remove Medicaid's bias toward institutional care. Financing of institutional care, the most costly form of care, has dominated Medicaid long-term care spending for decades. The high cost of institutional care coupled with the increased demand for nursing home care in the future due to population aging is of concern to federal and state officials. Proposals to strengthen home and community-based services are intended not only to constrain institutional care costs by preventing or delaying institutional admissions, but also to respond to the desire of persons with disabilities to reside outside of institutions.

Over the last three decades, a constellation of proposals have been made to level the playing field so that home and community-based services receive the same priority as institutional services in planning, delivering, and financing long-term care services under Medicaid. Although there has been a shift in recent years toward home and community-based services under Medicaid, federal sources provide more support for institutional care (primarily through Medicaid) than for home and community-based care, which most people prefer. Some state administrators have maintained that it is possible to control the rate of increase in long-term care costs by instituting systemic reform that includes: (1) controlling access to nursing home care; (2) expanding home and community-based care; (3) and balancing consumer choice with appropriate cost controls.¹

¹ See for example, CRS Reports, *Home and Community-Based Services: States Seek to Change the Face of Long-term Care*: Arizona (CRS Report RL32065), Florida (CRS Report RL32054), Illinois (CRS Report 32010), Indiana (CRS Report 32295), Maine (CRS Report RL32166), Oregon (CRS Report 32132), Pennsylvania (CRS Report 31850), and Texas (CRS Report 31968).



May 25, 2005

The Honorable Nathan Deal
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Mr. Chairman:

Thank you for the opportunity to testify before the Subcommittee on Health on April 27, 2005, at the hearing entitled, "Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform." Attached for the record are the answers to the follow-up questions sent on May 12, 2005, that were submitted by the Honorable John D. Dingell. If you or your staffs have any questions, please contact me at (202) 512-7118.

Sincerely,

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care

Enclosure

cc: The Honorable John D. Dingell

Enclosure

Enclosure

Questions from The Honorable John D. Dingell
Ms. Kathryn G. Allen, Director
Health Care -- Medicaid and Private Health Insurance Issues
U.S. Government Accountability Office
April 27, 2005
Subcommittee on Health
Hearing entitled: "Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform"

- 1. Ms. Allen, I understand that GAO has done some work on long-term care insurance. Some individuals claim that the availability of Medicaid is the reason that more individuals do not purchase long-term care insurance. Could you please briefly describe whether you have found this to be the case? What were the reasons you found that individuals did not buy such insurance?**

We highlighted several reasons that individuals did not purchase long-term care insurance during testimonies before the Senate Finance Committee and the Senate Special Committee on Aging during the past few years.¹ We noted that many people believe they will never need long-term care services so they do not purchase this coverage. Furthermore, some people mistakenly believe that public programs, including Medicaid and Medicare, or their own health care insurance will provide comprehensive coverage for long-term care services they will need. This can decrease the demand for long-term care insurance. Also, people may not purchase long-term care insurance because they may be concerned about whether they can afford the coverage now or in the future. Their unfamiliarity with and the uncertain value of long-term care insurance may deter some people from purchasing a policy. Other researchers have also reported that people with health problems may have problems purchasing long-term care insurance. Medical underwriting can prevent people from being eligible for coverage or can raise long-term care insurance premiums, making it even more difficult to afford.

¹GAO, *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services*, GAO-01-563T (Washington, D.C.: March 27, 2001) and GAO, *Long-Term Care Insurance: Better Information Critical to Prospective Purchasers*, GAO/T-HEHS-00-196 (Washington, D.C.: September 13, 2000).

2. While long-term care insurance may be a good solution for some individuals, I am concerned that if the Federal Government is to endorse this as an option for meeting future long-term care needs, we must take care to protect consumers against unscrupulous actors. I think that GAO also believes there is a public role in this regard. Could you briefly discuss some of the key consumer protections that Congress should consider?

We have previously testified about the importance of consumer information and protections in long-term care insurance policies as well as some of the problems and issues in the long-term care insurance market.² Consumers deserve complete and accurate information about any insurance product that they purchase, and sales of long-term care policies are not likely to increase significantly unless consumers are given adequate and understandable information to assess them. Although long-term care policies provide many options for individuals to create a policy to meet their needs and financial situation, these choices can complicate the purchasing decision. In addition, the specific policy information required to make reasoned decisions may not be readily available. Individuals must also understand what they are buying and what future changes, if any, they may face in their policy's coverage or premiums. This concern was highlighted by a class action lawsuit brought against two insurers in the 1990s, in which long-term care policyholders in North Dakota experienced increased premiums—for some, by more than 700 percent. In August 2000, the National Association of Insurance Commissioners (NAIC) amended its Long-Term Care Insurance Model Act and Regulation to strengthen consumer disclosure to address problems such as those highlighted by the class action suit. States, however, are not required to adopt the NAIC Model Act and Regulation. For example, NAIC reported in 2005 that about half of the states had adopted its premium rate increase provisions. Even if states did adopt the full NAIC Model Act and Regulation, experts have identified some areas that may deserve further consideration, such as the ability of states to enforce these standards and the need for additional assistance to help consumers evaluate their coverage options. We have not conducted work to assess the effectiveness of the NAIC standards in addressing these and other consumer protection issues; however, as part of a current study on the Federal Long-Term Care Insurance Program, we plan to compare several aspects of the federal program—including consumer protections—to other coverage available in the private long-term care insurance market.

²GAO, *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services*, GAO-01-563T (Washington, D.C.: March 27, 2001) and GAO, *Long-Term Care Insurance: Better Information Critical to Prospective Purchasers*, GAO/T-HEHS-00-196 (Washington, D.C.: September 13, 2000).

Response to Questions Submitted by Hon. John D. Dingell to the Congressional Budget Office

In response to the two questions (paraphrased below) that Congressman Dingell submitted on May 12, 2005, the Congressional Budget Office (CBO) provides the following reply for the record. The questions relate to the April 27, 2005, hearing on “Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform.”

Question. [Given that studies have predicted that some future retirees will not have enough money to provide for their basic needs], is it not possible that the potential benefit of using reverse mortgages to reduce Medicaid’s expenditures is overstated as individuals will need to use reverse mortgages to meet their basic retirement needs and will have little left over to self-finance their long-term care?

Answer. CBO believes that reverse mortgages or other strategies to use seniors’ housing wealth to reduce their Medicaid costs are unlikely to significantly affect future Medicaid expenditures. In general, seniors today hold relatively substantial wealth in the form of housing. But the amount of wealth held by the elderly is inversely related to their likelihood of having to be admitted into a nursing home. Those who are most likely to enter a nursing home have little, if any, financial resources, including the value of their home equity. For example, the median housing equity of households in which at least one senior had difficulty performing three or more activities of daily living (ADLs) is just under \$12,000, and the median for total financial assets (including housing equity) is only about \$48,000. At today’s prices, that would pay for only about eight months of nursing home care. Median annual income is also relatively low at \$15,600.

Financial well-being is negatively correlated with disability because people in lower-wage, blue-collar occupations are more likely to suffer injuries and are less likely to obtain medical services that help to preserve their health. In addition, people with severe impairments may be hurt financially by having to purchase in-home services while they still live in the community. In fact, many seniors enter nursing homes when they have no financial resources left to allow them to live in the community.

Those conclusions are based on data from the 2000 HRS/AHEAD survey (conducted by the Institute for Social Research at the University of Michigan), the most recent and comprehensive survey of the elderly. Although CBO adjusted the actual amounts reported here to 2005 dollars, the estimates may be somewhat understated because future retirees will have, on average, higher educational attainment and will be less likely to have worked in a blue-collar occupation.

Question. Given the fact that families are not currently saving enough to meet their basic needs in retirement, is it not possible that many will have insufficient discretionary income to spend on long-term care (LTC) insurance or that their money may be better spent on saving for retirement?

Answer. In a March 1999 memorandum titled *Projections of Expenditures for Long-Term Care Services for the Elderly*, CBO projected that private insurance would cover about 17 percent of LTC expenditures for the elderly by 2020. While that projected share of spending in 2020 is much larger than the share in 2005 (which is no more than 5 percent), it will still be smaller than spending by Medicare, Medicaid, or out of pocket. Reasons for that comparatively low share include the expectations of many elderly people that their long-term care needs will be taken care of by Medicare, Medicaid, and informal care provided by relatives or friends; the belief that they will never need LTC services; and a preference for spending their money on other goods and services rather than insurance.

Question from the Honorable John D. Dingell**Judith Feder, Ph.D.****Dean of the Public Policy Institute, Georgetown University****April 27, 2005****Subcommittee on Health****Hearing entitled: "Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform"**

Mr. Dingell: Dr. Feder, as Congress moves forward in addressing the nation's future long term care needs, what are the most important criteria or protections to include in the system?

Feder Response: First and foremost, it is essential that Congress recognize the importance of public support to making long-term care affordable. Now and in the future, private insurance will leave both people and services uncovered that people depend upon. It is clearly government's role to assure an adequate safety net—one that assures people access to quality care, in home if possible, and does not require them to impoverish themselves to receive it. If that safety net is to be available, regardless of where people live, federal dollars and federal rules for their use will be critical. Given this set of goals, the number one priority for use of federal dollars is to secure and extend the safety net Medicaid now provides—creating a floor of protection that exists in all states for all people in need. Any action that reduces federal support for Medicaid or, under the guise of "flexibility", allows states to ignore or depart from the current "entitlement" under Medicaid, will be a move in the opposite direction--undermining the safety net.



May 26, 2005

Honorable John D. Dingell
 House Committee on Energy and Commerce
 2125 Rayburn House Office Building
 Washington, DC 20510

Responding to Questions from the Honorable John D. Dingell, Subcommittee on Health, 4/27/05, "Long Term Care and Medicaid: Spiraling Costs and the Need for Reform"

Question 1. I understand that you are concerned with the effect that some of the policies in the President's FY 2006 budget will have on veteran's health care. Can you please discuss which policies and the potential problems they could cause?

In my written statement I said, "While almost all PVA members rely on the Department of Veterans Affairs (VA) for Health care and support services, potential changes to the VA system may have ramifications for other federal programs such as Medicaid." Congressman Steve Buyer questioned that statement and said, "as chair of the Veterans Affairs Committee, I know of no - zero, zip, none - changes now or even in the future that may have ramifications on Medicaid "

Please see the attached letter to Congressman Buyer further clarifying how changes in VA health care could impact Medicaid and or other federal programs.

Question 2. In your testimony you referenced statistics from the CMS Minimum Data Set that nationally there are 1,404,406 persons (by definition who are disabled" residing in nursing homes of whom 19.5 percent (273,859 disabled persons) have stated they want to live in the community. It seems to me that if we want to decrease Medicaid costs, one solution would be to create more community-based services and move people out of institutions. Can you describe the affect this would have on the quality of life for disabled persons?"

Getting out of an institution and living in a home or community based environment will only improve the quality of life for people with disabilities and or anyone else who is at risk of institutionalization. With personal assistance services, provided by a trained attendants or family care givers to help provide activities of daily living (ADL's), many people with disabilities can participate in all aspects of society, whether they are working, going to school, or simply living at home with family. For a person with a disability who is residing in a nursing home or institution, the opportunity to receive home and community based services is nothing short of "freedom."

Fifteen years ago, Congress passed the Americans with Disabilities Act (ADA) a comprehensive civil rights law which makes it illegal to discriminate against a person with a disability in employment, public accommodations, public services, transportation, and telecommunications. The passage of this law has enabled millions of people with disabilities to participate in all aspects of our society. Five years ago, the Supreme Court held in its Olmstead decision that unjustified isolation of institutionalization of people with disabilities is discriminatory and unlawful under the ADA. Changing the institutional bias in Medicaid would further enhance the goals of the ADA.

